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ABSTRACT

This document contains the 1989 annual report of the Senate Special Committee on Aging. It describes actions during 1989 by the Congress, the federal administration, and the U.S. Senate Special Committee on Aging, which are significant to America's older citizens. It also summarizes and analyzes the federal policies and programs that are of the most continuing importance for older persons, their families, and for those who will become older Americans in the future. Individuals chapters examine the issues of: (1) Social Security--old age, survivors, and disability insurance; (2) employee pensions; (3) taxes and savings; (4) employment; (5) Supplemental Security Income; (6) food stamps; (7) health care; (8) long-term care; (9) housing programs; (10) energy assistance and weatherization; (11) the Older Americans Act; (12) social, community, and legal services; and (13) the federal budget. Supplemental materials contained in the report include brief summaries of the 1989 hearings of the Senate Special Committee on Aging, a list of prints and information papers printed by the Senate Special Committee of Aging in 1989, a list of the staff of the committee, and a Committee publications list from 1961 to 1989. (NB)

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[COMMITTEE PRINT]

101st Congress
2d Session

SENATE

Rept. 101-249
Volume 1

DEVELOPMENTS IN AGING: 1989
VOLUME 1

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 66, SEC. 19, FEBRUARY 28, 1989

Resolution Authorizing a Study of the Problems of the Aged and Aging

March 6 (legislative day, January 23), 1990.—Ordered to be printed

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, February 28, 1990.

Hon. J. DANFORTH QUAYLE,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 66, Section 19, agreed to February 28, 1989, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1989, volume 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1989 by the Congress, the administration, and the U.S. Senate Special Committee on Aging, which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons, their families, and for those who hope to become older Americans in the future.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

DAVID PRYOR, *Chairman.*

SENATE RESOLUTION 66, SECTION 19, 101ST CONGRESS, 1ST SESSION [1]

SEC. 19. (a) In carrying out the duties and functions imposed by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4, 1977, and in exercising the authority conferred on it by such section, the Special Committee on Aging is authorized from March 1, 1989, through February 28, 1990, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel of any such department or agency.

(b) The expenses of the committee under this section shall not exceed $1,200,008, of which amount (1) not to exceed $33,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $800 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such Act).

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[1] Agreed to February 28, 1989.

PREFACE

In 1988, the passage of the Medicare Catastrophic Coverage Act dwarfed all other major developments in aging and health policy. In 1989, the repeal of the same Act similarly topped the list of legislative developments in this area.

Following the enactment of the catastrophic health care legislation, many in Congress were surprised by the vocal and extremely negative response to the new law. At the time of passage, most Members of Congress were aware that some older Americans were not pleased with the beneficiary-only financing provision. However, most concluded that this measure, which represented the largest expansion of Medicare since its 1965 enactment, would be welcomed as a major step forward toward improving Medicare benefits and worth its shortcomings.

Many Members were caught offguard with the groundswell of opposition to the new law and, in particular, its "surtax" financing mechanism. By early 1989, however, it had already become clear that the Congress was going to respond in some way to the discontent with the law.

Congressional responses to the concerns raised about the catastrophic health care law ranged from proposals to reduce or eliminate the surtax, to reduce or eliminate some benefits, or to repeal of the entire law. Members of the Senate Aging Committee and the Senate Finance Committee worked for months to develop acceptable alternatives that would reduce or eliminate the surtax while saving such important benefits as the new coverage of outpatient prescription drug costs. Despite their work, the efforts of many other Members throughout the Congress, and months of committee meetings on this issue, it became clear that no consensus on any option would emerge.

Finally, on December 13, 1989, President Bush signed Public Law 101-234 which repealed the Medicare expansions he endorsed just 16 months before. The only provisions that survived the repeal were the expanded Medicaid protections and the provisions establishing the U.S. Bipartisan Commission on Comprehensive Health Care or the "Pepper Commission", a commission charged to develop recommendations to address such issues as the need for long-term care and insurance for the millions of people under the age of 65 who are uninsured.

A similar fate was visited upon the Omnibus Budget Reconciliation Act of 1989. After months of work and prior to its final passage, the budget bill was stripped of many health care and income security provisions of importance to older Americans that were felt to be extraneous. Victims of this attempt to "cleanse" the budget process included legislation creating an independent Social Security agency and a measure directing the Social Security Administration to improve upon its Supplemental Security Income outreach program.

Despite the loss of major legislative initiatives, a number of notable measures of importance to the elderly were signed into law. These included long overdue legislation to reform and control Medicare reimbursement to physicians and a major rural health care initiative. The physician payment reform measure was crafted in response to spiraling Medicare Part B physician reimbursement costs, which were largely responsible for consistently and unacceptably high Medicare beneficiary premiums. The rural health care initiative was a response to hospital closings that were beginning to threaten access to needed health care in rural areas. Although the new initiative was welcomed by all citizens of rural areas, it was particularly welcome news to elderly residents, a group that is disproportionately represented in rural America.

The first session of the 101st Congress also was significant because it coincided with President George Bush's first year in office. After years of budget proposals that threatened many programs serving older Americans, aging advocates were encouraged by the "kinder and gentler" words espoused by the President. It was therefore disappointing to many that the President's first budget submission was largely a repeat of past Reagan Administration budgets that disproportionately targeted programs serving the elderly. The Medicare Program, in particular, was the recipient of such cuts. It is worth noting, however, that President Bush did keep to his campaign promise of not cutting Social Security.

The issue with the greatest continuing impact on the elderly in 1989 was the need to strike an acceptable balance between the desire to reduce the Federal deficit and the desire to address the unmet needs of the Nation. As has become practice, most new initiatives required financing which was either budget neutral or which would actually reduce the deficit. The primary exception to this rule was the above-mentioned rural health care initiative. However, although there was an increase in Medicare spending on this measure, the Medicare Program sustained an overall multi-billion dollar cut.

As a result of the need to address the Federal deficit problem, limited progress was made toward resolving the many major challenges facing older Americans including: The increasing burden of skyrocketing prescription drug costs, the lack of protection against the devastating costs of long-term illness, and the continued susceptibility of the elderly to consumer fraud and physical, emotional, and financial abuse.

Although legislative solutions to these and other major challenges facing older Americans were not passed, the Committee raised public consciousness on a number of important issues. These included: (1) Rising prescription drug costs and on ways to control them; (2) the intergenerational need for long-term care and the necessity to recognize the special problems delivering such care to rural America; (3) how the drug crisis victimizes older Americans as drug addicts prey on the elderly to financially support their habits or rely on them to take care of their crack-addicted babies; (4) the degree that market abuse remains a major problem in the supplemental Medigap insurance industry; and (5) the overuse and abuse of physical restraints in nursing homes.

The Committee's work on prescription drug prices serves as a good example of how substantive Committee involvement can raise an issue, provide needed information to elderly and their advocates, policymakers, and the media, and provide sound policy options for congressional consideration. The information presented at hearings and in staff reports on rising prescription drug costs and on ways to address this problem significantly contributed to the Congress' understanding of this issue. By the end of 1989, the two staff reports, "Prescription Drug Prices: Are We Getting Our Money's Worth?" and "Skyrocketing Prescription Drug Prices: Turning a Bad Deal Into a Fair Deal," were being used as a basis for the development of legislation to be introduced in 1990.

With its eight Washington, DC-based hearings, its six field hearings, its sponsorship of a number of seminars, and its production and release of information prints, the Special Committee on Aging produced an impressive record of accomplishments during the first session of the 101st Congress. Beyond what already has been mentioned, the Committee held hearings in Washington, DC, on topics ranging from Social Security's toll-free telephone system to the Health Care Financing Administration's implementation of the 1987 nursing home reform law to age discrimination. Outside the Capitol, six Senators held field hearings on topics such as rural health care and the utilization of older Americans as a valuable and experienced community resource. Two of these hearings were joint Aging Committee/Pepper Commission hearings.

Notably, substantive legislation inspired by Committee work was drafted, introduced, and in some cases signed into law. These initiatives included bills cosponsored by many Aging Committee members that addressed such issues as the need for the maintenance and improvement of access to health care in rural areas, abuses in Social Security's Representative Payee program, the need to assure the independence of Social Security Administrative Law Judges, and the desirability of removing the Social Security Trust Funds (and their reserves) from the unified budget.

Following these modest achievements, where do we now stand on issues of importance to our Nation's seniors? What problems remain on the congressional agenda? There is no question that much remains to be done.

The staggering problem of access to health care for the aged and non-aged alike has dominated the legislative agenda during the past year. Thirty-seven million Americans under the age of 65 lack health insurance. One-third of the U.S. population with incomes below the poverty level are uninsured. These statistics highlight gaps in protection for even the most needy Americans. Likewise, while nearly 98 percent of older Americans are enrolled in Medicare, the elderly remain unprotected against the often-catastrophic costs of long-term care and outpatient prescription drugs. Moreover, although these are needs of all Americans, access to health care in inner city and rural America continues to be a particularly overwhelming and unmet challenge.

Solving these and other daunting problems requires a major commitment on the part of the Federal Government, as well as renewed efforts by the private sector. It remains to be seen, however, if a Federal Government that faces significant budget constraints for the foreseeable future will be up to its task.

The second session of the 101st Congress will be notable for a debate on the merits of varying Social Security and capital gains tax cutting proposals. Add this to the fact that 1990 is an election year and it is safe to predict that the upcoming year will be a time in which it will be particularly difficult to discuss significant revenue raising alternatives to fund a wide variety of domestic needs. Moreover, following repeal of the Medicare Catastrophic Coverage Act, many Members of Congress will be hesitant to support major and expensive health and aging policy reforms unless they feel certain such legislation is strongly supported by the constituents who will be footing the bill.

Juxtaposed to this intimidating environment will be the release of the Pepper Commission's long-awaited report and recommendations. The job of the Special Committee on Aging, the Pepper Commission, and advocates of needy populations of all ages is to raise the aging and health agenda to a higher level of priority in the Congress and, in particular, in the Executive Branch.

The above record demonstrates a productive year for the Committee. The report that follows discusses developments of importance to older Americans in 1989. In line with changes implemented in previous years, the report surveys only Federal policies and programs and focuses primarily on the major policy issues facing Congress and the legislative activity on these issues that transpired in 1989.

Similar to last year, comprehensive demographic and statistical information is not included in this year's report. Updated data can be found in a recently released Aging Committee information paper entitled "Aging America: Trends and Projections."

We are proud to acknowledge the dedicated work of the authors of this report, the staff of the Special Committee on Aging. This report is a synthesis of the extensive working knowledge they bring to the Committee.

The graying of America presents us with significant challenges and opportunities. Providing for the health, income, and housing needs of this ever-growing older population are only a few of the challenges. We must also seek better ways to enable older Americans to remain productive and independent. Our greatest challenge then is to expand opportunities, to put to use the full talents of this vast resource so that the promise of long life is worth living.

David Pryor,
Chairman.
John Heinz,
Ranking Minority Member.

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101st Congress
2d Session

SENATE

Rept. 101-249
Volume 1

DEVELOPMENTS IN AGING: 1989—VOLUME 1

March 6 (legislative day, January 23), 1990.—Ordered to be printed

Mr. Pryor, from the Special Committee on Aging, submitted the following

REPORT

Chapter 1

SOCIAL SECURITY—OLD AGE, SURVIVORS, AND DISABILITY

OVERVIEW

In 1989, Social Security continued on a stable path. The key developments included a major change in Social Security Administration leadership and an important debate over the role of Social Security in the Federal budget. Continued growth in Social Security reserves exemplified stability. Yet, the fact that Congress expanded the Social Security tax base in 1989 to help reduce the deficit in the final days of 1989, New York Senator Daniel Patrick Moynihan proposed a large reduction of Social Security payroll taxes. His proposal catapulted to the top of the Social Security agenda for 1990.

The President and Members of Congress in 1989, immediately following an election year, carried out campaign commitments most had made to protect Social Security from budget cuts. No controversial benefit reductions were seriously proposed affecting Social Security programs. On January 1, 1990, Social Security beneficiaries quietly received a 4.7-percent increase to offset inflation.

In 1989, a number of legislative proposals affecting Social Security were seriously considered in deliberations over the deficit reduction bill, known as budget reconciliation. Although the House of Representatives and the Senate Finance Committee approved significant programmatic and administrative Social Security reforms, the bulk of these proposals were "stripped" from the final package. Political pressures had arisen to pass a deficit reduction bill free from "extraneous," or non-deficit reducing provisions. Proposals that were stripped included a liberalization of the earnings test, a reorganization making SSA independent from the Department of Health and Human Services, and a comprehensive package of representative payee reforms. Many other valuable reforms were also lost in the process. As a result, the only legislative changes in 1989 were a series of relatively noncontroversial amendments finally adopted as part of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239).

Proponents of insulating Social Security programs from politics achieved progress in 1989. Program benefit cuts were off the table in the 1989 debate over deficit reduction. Instead, debate centered on achieving budgetary and organizational independence for Social Security. Although the House and Senate provisions to make SSA an independent agency proposed differing organizational structures, and no final package was agreed upon by both bodies, the concept advanced farther than ever before. New studies were made, new proposals were hammered out by the authorizing committees, and a more fertile field was sown for progress in 1990. Also in 1989, removing Social Security trust funds from Gramm-Rudman deficit reduction targets was agreed upon in principle by the leadership of both Houses of Congress and key leaders of both political parties.

The urgency of removing the trust funds from Gramm-Rudman calculations accelerated with Moynihan's tax cut proposal. Moynihan had played a key role in crafting the legislation which had created surpluses in the Social Security trust funds. When he proposed to cut the taxes to eliminate the surpluses, returning the Social Security system to a pay-as-you-go basis, it hit a receptive audience. As always, tax cuts are politically attractive. The question remains whether they are responsible. Moynihan commands respect and authority as a champion of the Social Security system. Yet his proposal received support from groups which had previously supported dismantling the Social Security system. Many traditional voices advocating a strong Social Security system retained serious reservations about the Moynihan proposal. Yet significantly, the chairman of the Budget Committee expressed his support for a reduction in Social Security taxes linked to deficit reduction. These tax cutting proposals promise to raise the most controversial and widely debated issues in 1990.

In 1989, as promises to be the case in 1990, the debate over Social Security has been driven by concern over the Nation's mounting budget deficit. Although Social Security is a self-financing program that has not contributed to the deficit, it nevertheless plays an enormous role in determining the apparent size of the deficit. Under the Gramm-Rudman law, Social Security trust funds are factored into the deficit totals used to determne the deficit reduction targets that the Congress must meet to avoid across-the-board cuts in Federal spending. Because of this accounting method, the deficit totals are reduced on paper by the amount of the Social Security reserves. Other self-financing trust funds have the same effect, but not to the extent of Social Security. In 1989 alone, the inclusion of Social Security reserves offset $55 billion in the general revenue deficit. Thus, the larger the Social Security trust funds, the smaller the apparent size of the deficit.

At the same time, larger Social Security trust funds means that the Federal Government needs to borrow less from the public, thereby keeping interest rates lower. Under law, any Social Security reserves are invested in interest-paying Treasury securities and the assets then used to finance other Federal programs. By borrowing from itself, the Government does not crowd out those in the private sector seeking financing.

The movement to clarify Social Security's relationship to the budget is certain to progress in 1990. Many leading proposals suggest removing the trust funds from the deficit calculations immediately. They propose stretching Gramm-Rudman targets for several years to accomplish a true balanced budget. The Bush Administration recommended using the Social Security surpluses to buy-back the Federal debt. The outcome of these budget reform proposals will be driven by the debate over the Social Security tax structure.

A new Commissioner, Gwendolyn S. King, replaced Dorcas Hardy at the helm of SSA, bringing with her in the last half of 1989 a revitalization of SSA's commitment to quality person-to-person service. King confronted problems inherited by her predecessor head-on: she addressed SSA staff directly to stem a decline in staff morale revealed in internal studies showing morale at an all-time low; she reassessed SSA's move toward a nationwide 800-number telephone system in response to system overload; and she prevented further staff reductions beyond the 17,000 in effect when she took office. She signaled a new direction for the agency.

In 1989, legislative efforts to supervise Social Security Disability Insurance (SSDI) centered on beneficiares' rights with respect to administrative law and legal representation. The Senate Finance Committee approved proposals to insulate the administrative law system at SSA from politics, and to streamline the attorney fee process and ensure the availability of legal assistance. Continuation of disability benefits pending appeal was extended for 1 year permitting SSDI beneficiaries to protect their benefits without interruption by the legal process. Accordingly, concern continued with the implementation of the Social Security Disability Benefits Reform Act of 1984. Attention was paid to the manner in which the law was carried out, and problems that continued to plague the disability determination process.

A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

1. Background

Title II of the Social Security Act, the old age and survivors insurance (OASI) and disability insurance (DI) program—together named the OASDI program—is designed to replace a portion of the income an individual or a family loses when a worker in covered employment retires, dies, or becomes disabled. Known more generally as Social Security, monthly benefits are based on a worker's earnings. In October 1989, close to $19 billion in monthly benefits were paid to Social Security beneficiaries, with payments to retired workers averaging $556 and those to disabled workers $540. Administrative expenses were $2.3 billion or 1 percent of total benefit payment during that period, showing a small drop from the preceding fiscal year.

It is fair to say that the Social Security Program touches the lives of nearly every American. In 1989, there were over 39 million Social Security beneficiaries. Under the program, retired workers numbered over 24 million, accounting for 62 percent of all beneficiaries. Disabled workers and dependent family members numbered over 4 million, comprising about 10 percent of the total, while surviving family members of deceased workers totaled over 7 million or 18 percent of all beneficiaries. During the same period, about 130 million workers were in Social Security-covered employment, representing approximately 94 percent of the total American work force.

In 1989, Social Security contributions were paid on up to $48,000 of earnings, a wage cap that is annually indexed to keep pace with inflation. Workers and employees alike paid a 7.51 percent of earnings (of which 1.45 percent represents contributions to the Hospital Insurance portion of Medicare). For the self-employed, the payroll tax is doubled, or 15.02 percent of earnings. In 1990, the tax rises to 7.65 percent, or 15.30 percent for the self-employed.

Social Security is accumulating large reserves in its trust funds. As a result of increases in the Social Security payroll mandated by the Social Security Act Amendments of 1983, the influx of funds into the Social Security is increasingly exceeding the outflow in benefit payments. In 1989, the Social Security reserves totalled an estimated $170 billion, compared with $110 billion in 1988.

(A) HISTORY AND PURPOSE

Social Security emerged from the Great Depression as one of the most solid achievements of the New Deal. Created by the Social Security Act of 1935, the program continues to grow and become even more central to larger numbers of Americans. The sudden economic devastation of the 1930's awakened Americans to their vulnerability to sudden and uncontrollable economic forces with the power to generate massive unemployment, hunger, and widespread suffering. Quickly, the Roosevelt Administration developed and implemented strategies to protect the citizenry from hardship, with a deep concern for future Americans. Social Security succeeded and endured because of this effort.

Although Social Security is uniquely American, the designers of the program drew heavily from a number of well-established European social insurance programs. As early as the 1880's, Germany had begun requiring workers and employers to contribute to a fund first solely for disabled workers, and then later for retired workers as well. Soon after the turn of the century, in 1905, France also established an unemployment program based on a similar principle. In 1911, England followed by adopting both old-age and unemployment insurance plans. Borrowing from these programs, the Roosevelt Administration developed a social insurance program to protect workers and their dependents from the loss of income due to old-age or death. Roosevelt followed the European model: government-sponsored, compulsory, and independently financed.

While Social Security is generally regarded as a program benefiting the elderly, the program was designed within a larger generational context. According to the program's founders, by meeting the financial concerns of the elderly, some of the needs of young and middle-aged would simultaneously be alleviated. Not only would younger persons be relieved of the financial burden of supporting their parents, but also would gain a new measure of income security for themselves or their family in the event of their retirement or death. Disability insurance was pioneered in the 1950's.

President Roosevelt viewed the new and experimental Social Security Program as the centerpiece "for the kind of protection America wants." In the more than half a century since the program's establishment, Social Security has been expanded and changed substantially. Nevertheless, the underlying principle of the program—a mutually beneficial compact between younger and older generations—remains unaltered and accounts for the program's lasting popularity.

Social Security benefits, like those provided separately by employers, are related to each worker's own average career earnings. Workers with higher career earnings receive greater benefits than workers with low earnings. Each individual's own earnings record is maintained separately for use in computing future benefits. The earmarked payroll taxes paid to finance the system are often termed "contributions" to reflect their role in accumulating credit.

Social Security serves a number of essential social functions. First, Social Security protects workers from unpredictable expenses in support of their aged parents or relatives. By spreading these costs across the working population, they become smaller and more predictable. At the same time, universal coverage limits the degree to which the burden of supporting aged or disabled persons falls inadvertently to society.

Second, Social Security provides income insurance, providing workers and their families with a "floor of protection" against sudden loss of their earnings due to retirement, disability, or death. By design, Social Security only replaces a portion of the income needed to preserve the beneficiary's previous living standard and is intended to be supplemented through private insurance, pensions, savings, and other arrangements made voluntarily by the worker.

Third, Social Security provides the individual wage earner with a basic cash benefit upon retirement. Significantly, because Social Security is an earned right, based on contributions over the years on the retired or disabled worker's earnings, Social Security ensures a financial foundation while maintaining beneficiaries' self-respect.

Social Security provides a unique set of protections not available elsewhere. Some criticize Social Security for its mix of functions. Some argue that Social Security should be a welfare program, providing basic benefits to the poor and allowing middle and upper income workers to invest their earnings in private vehicles, such as IRA's. Such an approach would undermine the widespread political support that has developed for the broad-based functions of the program.

The Social Security Program has come of age in the 1980's. In this decade, the first generation of lifelong contributors retired and drew benefits. Also during this decade, payroll tax rates and the relative value of monthly benefits finally stabilized at the levels planned for the system. Large reserves accumulating in the trust funds leave Social Security on a solid footing heading into the 1990's.

(B) FINANCING

(1) Financing in the 1970's

As recently as 1970, OASDI trust funds maintained reserves equal to a full year of benefit payments, an amount considered adequate to meet any disruptions in expenditures or income due to unforeseen economic fluctuations. When Congress passed the 1972 amendments to the Social Security Act, it was assumed that the economy would continue to follow the pattern prevalent in the 1960's: Relatively high rates of growth and low levels of inflation. Under these conditions, Social Security revenues would have adequately financed benefit expenditures, and trust fund reserves would have remained sufficient to weather economic downturns.

The experience of the 1970's was considerably less favorable than forecast. The energy crisis, high levels of inflation and slow wage growth increased expenditures in relation to income. The Social Security Amendments of 1972 had not only increased benefits by 20 percent across-the-board, but also provided automatic benefit increases which were indexed to the CPI. Inflation fueled large benefit increases, with no corresponding increase in payroll tax revenues due to lower real wage growth. Further, the recession of 1974-75 raised unemployment rates dramatically, lowering payroll tax income. Finally, a technical error in the initial benefit formula created by the 1972 legislation led to "over-indexing" benefits for certain new retirees, creating an additional drain on trust fund reserves.

In 1977, recognizing the rapidly deteriorating financial status of the Social Security trust funds, Congress responded with new amendments to the Social Security Act. The Social Security Act of 1977 increased payroll taxes beginning in 1979, reallocated a portion of the Medicare (HI) payroll tax rate to OASI and DI, and resolved some technical problems in the method of computing initial benefit amounts. These changes were predicted to produce surpluses in the OASDI program beginning in 1980, with reserves accumulating to 7 months of benefit payments by 1987.

Again, however, the economy did not perform as well as predicted. The long-term deficit, which had not been fully reduced, remained. The stagflation occurring after 1979 resulted in annual CPI increases exceeding 10 percent which contributed to the depletion of funds. Real wage changes had been negative or near zero since 1977, and in 1980, unemployment rates exceeded 7 percent. As a result, annual income to the OASDI program continued to be insufficient to cover expenditures. Trust fund balances declined from $36 billion in 1977, to $26 billion in 1980. Lower trust fund balances, combined with rapidly increasing expenditures, brought reserves down to less than 3 months' benefit payments by 1980.

In 1981, a number of proposals were introduced to restore short- and long-term solvency to Social Security. However, the debate over the future of Social Security proved to be very heated and controversial. Enormous disagreements on policy precluded quick passage of comprehensive legislation. At the end of 1981, in an effort to break the impasse, the President appointed a 15-member, bipartisan, National Commission on Social Security Reform to search for a feasible solution to Social Security's financing problem. The Commission was given a year to develop a consensus approach to financing the system.

Meanwhile, the condition of the Social Security trust funds worsened. By the end of 1981, OASDI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for less than 2 months. By November 1982, the OASI trust fund had exhausted its cashable reserves and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

The delay in the work of the National Commission deferred the legislative solution to Social Security's financing problems to the 98th Congress. Nonetheless, the Commission did provide clear guidance to the new Congress on the exact dimensions of the various financing problems in Social Security, and on a viable package of solutions.

(2) The Social Security Amendments of 1983

Once the National Commission on Social Security Reform reached agreement on its recommendations, Congress moved quickly to enact legislation to restore financial solvency to the OASDI trust funds. This comprehensive package improved financing by $166 billion between 1983 and 1989, and eliminated a deficit which had been expected to average 2.1 percent of payroll over 75 years.

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the burden restoring solvency to Social Security equitably between workers, Social Security beneficiaries, and transfers from other Federal budget accounts. The Commission's recommendations split the near term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts—including contributions from new Federal employees. The long-term proposals, however, shifted almost 80 percent of the costs to future beneficiaries.

The major changes in the OASDI program resulting from the 1983 Social Security Amendments were in the areas of coverage, the tax treatment, and annual adjustment of benefits, and payroll tax rates. Key provisions included:

Coverage.—All Federal employees hired after January 1, 1984 were covered under Social Security, as were all current and future employees of private, nonprofit, tax-exempt organizations. State and local governments were prohibited from terminating coverage under Social Security.

Benefits.—COLA increases were shifted to a calendar year basis, with the July 1983 COLA delayed to January 1984. A COLA fail-safe was set up so that whenever trust fund reserves do not equal a certain fraction of outgo for the upcoming year—15 percent until December 1988; 20 percent thereafter—the COLA will be calculated on the lesser of wage or price index increases.

Taxation.—One-half of Social Security benefits received by taxpayers whose income exceeds certain limits—$25,000 for an individual and $32,000 for a couple—were made subject to income taxation, with the additional tax revenue funneled back into the retirement trust fund.

Payroll taxes.—The previous schedule of payroll tax increases was accelerated, and self-employment tax rates were increased.

Retirement age increase.—An increase in the retirement age from 65 to 67 was scheduled to be gradually phased in between the years 2000 and 2022.

(3) Trust Fund Projections

The Social Security trust fund income and outgo are tied to a variety of economic and demographic factors, including economic growth, inflation, unemployment, fertility, and mortality. To predict the future state of the OASI and DI trust funds, estimates are prepared using four sets of assumptions related to these factors. Alternative I is designated as the most optimistic, followed by intermediate assumptions II–A and II–B, and finally the more pessimistic alternative III. The intermediate II–B assumption is the most commonly used scenario. Actual experience, however, could fall outside the bounds of any of these assumptions.

One indicator of the health of the Social Security trust funds is the contingency fund ratio, a number which represents the ability of the trust funds to pay benefits in the near future. The ratio is the percentage of 1 year's payments which can be paid with the reserves available at the beginning of the year. Therefore, a contingency ratio of 50 percent represents 6 months of outgo.

Trust fund reserve ratios hit a low of 14 percent at the beginning of 1983, but increased to approximately 57 percent by 1989. Based on intermediate assumptions, the contingency fund ratio is projected to increase gradually to 77 percent by the beginning of 1990. Even under pessimistic assumptions, assets are projected to reach 178 percent by the year 2000.

(a) OASDI Near-Term Financing

Social Security trust fund assets are expected to increase over the next 5 years. Indeed, according to the 1989 OASDI trustees report, OASDI assets will be sufficient to meet the required benefit payments throughout and far beyond the upcoming 5-year period. Under all but the most pessimistic assumptions, both the OASI and DI programs will remain solvent on their own for many years. However, should conditions deteriorate drastically during the coming 10 years, DI trust fund assets could decline to dangerously low levels.

The continued expansion in the OASDI reserves will be aided by the 1990 payroll tax increase—from 6.06 percent in 1989 to 6.20

percent in 1990. The OASDI reserves are expected to steadily build as a result both of the 1990 tax increase and an anticipated stabilization of the number of covered workers in relation to OASDI beneficiaries.

(4) OASDI Long-Term Financing

In the long run, the Social Security trust funds will experience three decades of rapid growth, followed by continuing annual deficits thereafter. Under the intermediate assumptions, over the next 75 years as a whole the cost of the program is expected to exceed its income by 5.4 percent. However, the expected surplus revenue of the system over the next 20 or 30 years provides ample time to monitor the program and take actions to ensure its solvency.

It should be emphasized that the OASDI trust fund experience in each of the three 25-year periods between 1989 and 2063 varies considerably. In the first 25-year period—1989 to 2013—reserves are expected to exceed costs by 2.14 percent of taxable payroll. As a result of these surpluses, contingency fund ratios are expected to build to approximately 312 percent by the year 2000.

In the second 25-year period—2014 to 2038—the financial condition of OASDI is expected to continue improving in the early years, but begin deteriorating soon thereafter. Trust fund reserves are expected to peak in 2014 at 547 percent of annual expenditures by 2015, and decline throughout the rest of the 25-year period, reaching 162 percent of annual expenditures by the beginning of 2039. Positive annual balances are expected through the year 2017, with negative balances occurring thereafter. Deficits are projected to peak around the year 2035, at 3.47 percent of taxable payroll. This combination of surpluses and deficits will result in an average deficit of 1.88 percent of taxable payroll over this 25-year period.

The third 25-year period—2039 to 2063—is expected to be one of continuous deficits. Program costs will essentially continue to grow throughout the period, and the gap between revenue and costs will accelerate. By the end of this period, continuing deficits are expected to have depleted the trust funds. Under intermediate assumptions, exhaustion of reserves is projected to occur by 2046. If considered separately, depletion of DI reserves is expected by 2025, while OASI trust fund exhaustion is projected for the year 2049. Annual OASDI deficits over the 25-year period are expected to average 3.72 percent of taxable payroll.

(a) Midterm surpluses

In the years between 1990 and 2015, it is projected that Social Security will receive far more in income than it must distribute in benefits. Under current law, these surpluses will be invested in interest-bearing Federal securities, and will be redeemable by Social Security in the years in which benefit expenditures exceed payroll tax revenues—2018 through 2063. During the years in which the assets are accumulating, these reserves will far exceed the amount needed to buffer the OASDI funds from unfavorable economic conditions. As a matter of policy, there is considerable controversy over the purpose and extent of these surplus funds, and the political and economic implications they entail.

During the period in which Social Security trust fund surpluses are accumulating, the surplus funds can be used to finance other Government expenditures. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing income taxes to buttress Social Security. In essence, the assets Social Security accrues represent internally held Federal debt, which is equivalent to an exchange of tax revenues over time.

Though the net effect on revenues of this exchange is the same as if Social Security taxes were lowered and income taxes raised in the 1990's and Social Security taxes raised and income taxes lowered in 2020, the two tax methods have vastly different distributional consequences. The significance lies with the fact that there is incentive to spend surplus revenues in the 1990's. The growing trust funds surpluses enable the Congress to spend more money elsewhere without raising taxes or borrowing from private markets. Around 2020, when the trust funds will begin to experience a negative balance, revenues will be needed to meet obligations to growing numbers of retired persons. At some point either general revenues will have to be increased or spending will have to be drastically cut when the debt to Social Security has to be repaid.

(b) Long-term deficits

The long-run financial strain on Social Security is expected to result from the problems of financing the needs of an expanding older population on an eroding tax base. The expanding population of older persons is due to longer age spans, earlier retirements, and the unusually high birth rates after World War II, producing the so-called baby-boom generation who will retire beginning around 2010. The eroding tax base in future years is forecast as a result of relatively low fertility rates in the recent past, and as projected for the future.

This relative increase in the number of beneficiaries will pose a problem if the Social Security tax base is allowed to erode. If current trends continue and nontaxable fringe benefits grow, less and less compensation will be subject to the Social Security payroll tax. In 1950, fringe benefits accounted for only 5 percent of total compensation, and FICA taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation. Continuation in this rate of growth in fringe benefits, as projected by the Social Security actuaries, might eventually exempt over one-quarter of compensation from Social Security taxes. This would be a substantial erosion of the Social Security tax base and might undermine the long-term solvency of the system.

While the absolute cost of funding Social Security is expected to increase substantially over the next 75 years, the cost of the system relative to the economy as a whole will not rise as greatly. Currently, Social Security benefits cost approximately 4.5 percent of the GNP. Under intermediate assumptions—with 1.3 percent real wage growth—Social Security is expected to rise to 6.8 percent of the GNP by 2035, declining to 6.7 percent by 2060.

Although there is no question that surpluses in the Social Security trust funds will build up well beyond the turn of the century, it nevertheless must be remembered that Social Security remains vulnerable to general economic conditions and should those conditions deteriorate, the Congress may need to revisit the financing of the system. Furthermore, Social Security is not immune from political pressures to change its structure, notwithstanding its financial condition. Indeed, political and economic pressures in coming years to use the trust funds to reduce the Federal budget deficit may overshadow the attention paid to maintaining Social Security's solvency.

2. Issues

(A) SOCIAL SECURITY'S RELATION TO THE BUDGET

Over the last decade, Social Security has repeatedly been entangled in debates over the Federal budget. While the inclusion of Social Security trust fund shortages in the late 1970's initially had the effect of inflating the apparent size of the deficit in general revenues, the surpluses that have accumulated in recent years have served to mask its true magnitude. In fact, many Members of Congress contend that the inclusion of the surpluses has disguised the enormity of the Nation's fiscal problems and delayed true deficit reduction. Some have called for a reduction of payroll taxes to halt the use of surpluses to finance general government operations. For these same reasons, there has been concern over the temptation to cut Social Security benefits to further reduce the apparent size of the budget deficit.

Many noted economists advocate the removal of the trust funds from deficit calculations. They say that the current use of the trust funds contributes to the country's growing debt, and that the Nation is missing tremendous opportunities for economic growth. A January 1989 report states that if the Federal deficit was reduced to zero, and the reserves were no longer used to offset the deficit, there would be an increase in national savings, and improved productivity and international competitiveness. The National Economic Commission, which released its report in March 1989, disagreed among its members over how to tame the budget deficit. Yet, the one and only recommendation upon which they unanimously agreed is that the Social Security trust funds should be removed from the Gramm-Rudman-Hollings deficit reduction process.

Taking Social Security off-budget was partially accomplished by the 1983 Social Security amendments and, later, by the 1985 Gramm-Rudman-Hollings Act. The 1983 amendments required that Social Security be removed from the budget process by fiscal year 1993 and the subsequent Gramm-Rudman-Hollings law accelerated this removal to fiscal year 1986. To further protect the Social Security trust funds, Social Security was excluded from any budget documents, budget resolutions, and reconciliation, and barred from any Gramm-Rudman-Hollings across-the-board cut or sequester. Inclusion of Social Security changes as part of a budget resolution or reconciliation bill is subject to a point of order which may be waived by either body. However, administrative funds for SSA were not placed off-limits from a budget sequester.

Despite these changes, the Social Security trust funds are still inextricably a part of the budget process. While the official budget does not count Social Security, the program's trust funds, which will continue to run a surplus until around 2020 when the baby boomers retire, are factored into the deficit reduction targets under Gramm-Rudman-Hollings. Were it not for this inclusion, much deeper budget cuts in Federal spending would be required to reach the law's deficit reduction targets. Indeed, Congressional Budget Office estimates show that if the OASDI trust funds were not being included in deficit calculations, additional cuts or revenue increases of $65 billion would be required to meet the Gramm-Rudman-Hollings target of a balanced budget by fiscal year 1991.

In 1989, legislation was introduced in the Senate which would halt the use of the Social Security trust funds to mask the true size of the deficit. Senator Heinz introduced S. 1752, which would remove the trust funds from the deficit reduction calculations beginning in fiscal year 1991, and extend the Gramm-Rudman-Hollings targets through fiscal year 1997. The current targets under Gramm-Rudman-Hollings would be adjusted upward by an amount equal to the current CBO estimate of the OASDI surplus for fiscal years 1991, 1992, and 1993. In other words, changing the Gramm-Rudman-Hollings targets for these fiscal years would not cause Congress to have to cut spending or raise additional revenue in fiscal years 1990–93. To protect the trust funds once they are taken off-budget, a 60-vote majority would be required before changes could be made in Social Security expenditures, unless there are offsetting savings or revenue increases to pay for the increased benefits. Senators Moynihan and Hollings have introduced similar bills.

In late 1989, Senate Majority Leader George Mitchell and Speaker of the House Thomas Foley issued statements at a joint appearance committing themselves to working for legislative removal of the trust funds from the Gramm-Rudman targets. During consideration of a bill to extend the public debt limit to $3.12 trillion, Senator Heinz proposed to offer an amendment to remove the trust funds from the "deficit counting game." Due to time constraints, and because the Majority Leader and other Senators promised to fully debate the issue early in the next session, the amendment was not offered at that time. A bipartisan approach to taking Social Security off-budget remains at the top of Congress' legislative agenda in 1990. How that debate will take shape will be influenced by questions raised by proposals to reduce Social Security payroll taxes, an issue which has led to some partisan wrangling. At a minimum, it can be expected that a serious movement will progress toward taking the trust funds out of the Gramm-Rudman process.

As long as Social Security is included in the Gramm-Rudman deficit reduction targets, the American public will continue to be misled about the true status of the Federal deficit, and Social Security will remain a potent target for deficit reduction efforts. Members of Congress are concerned that they must take steps to prevent erosion of the public's confidence in the system.

(B) ADMINISTRATION OF THE SOCIAL SECURITY PROGRAMS

Over time, Congress has monitored the performance of the SSA in carrying out its most basic mission—high-quality service to the public. In the 1950's and 1960's SSA was viewed as a flagship agency, marked by high employee morale and excellence in management and services. In the past 15 years, however, many have contended that the agency has lost its edge, and the quality of service has declined. Factors cited as causing this decline include new agency responsibilities, including the creation of SSI in 1972, staff reductions in the 1980's, inadequate administrative budgets, multiple reorganization efforts, and the fact that SSA has had high turnover in the Commissioner's office in the last 15 years. Many claim that the agency has sacrificed the quality of service to the public in an effort to cut costs through technology, and that public confidence in the agency consequently has declined. Despite a major investment by Congress, SSA remains troubled by computer and technology problems.

These criticisms have led Congress to intensify oversight of SSA, including numerous Congressional hearings and requests for General Accounting Office (GAO) investigations of SSA problems. One outcome has been an ongoing review of the agency by the GAO. During the past several years, GAO has released a series of reports on SSA staff reductions and their effect on the quality of service provided to the public, payment accuracy to beneficiaries, problems with the agency's creation of a national 800-number system and fragmented leadership. Legislative proposals progressed from these concerns in 1989, including the creation of an independent SSA and requirements to perform specific service improvements.

(1) New Commissioner of Social Security

Gwendolyn S. King replaced Dorcas Hardy as Commissioner of SSA on August 1, 1989. A Capitol Hill veteran who handled aging issues for Senator John Heinz, she signaled a new direction in the leadership at SSA. With a different approach to both immediate problems and long-range plans, her ascendancy revitalized SSA's traditional commitment to quality person-to-person service. She inherited a raft of problems from her predecessors, and struggled with limited resources to chart a course that enables the Social Security programs to assist hard to reach Americans, such as those in need of Supplemental Security Income.

King's achievements were considerable in the first half of 1989. She promoted outreach for Americans in need of SSI benefits. She moved to reassess the role of a nationwide 800-number telephone within SSA's service system in response to system overload. She worked with conviction to redress mistakes made when thousands of needy SSI recipients were improperly suspended from the program, and to prevent future mistakes. She sought to bolster morale among employees in response to internal and union studies showing morale at an all-time low. She furthered that goal by successfully fighting staff reductions which were being proposed by officials at the Office of Management and Budget.

Commissioner Hardy had led in the creation of a Strategic Plan that promoted replacing people with technology to deliver services to participants in the Social Security system. The attempt weakened SSA's service delivery system. King rededicated the agency to a more humanistic mode of service delivery. In 1990, she will have to stretch to achieve her admirable goals with SSA's limited resources.

(2) Staff Reductions

Efforts by SSA over recent years to reduce its number of field offices and employees have continued to raise concerns about a deterioration in the agency's quality of public service. In 1989, SSA personnel totalled 63,000, down 17,000 from the staffing level of 1985. Officials at the Office of Management and Budget reportedly were proposing an additional reduction of 5,000 in SSA staff as part of President Bush's 1990 budget, despite growing and documented evidence of service problems resulting from previous staff cuts. Commissioner King, who had vowed to "fight like a junkyard dog" against such proposals, prevailed against OMB. Reportedly, President Bush himself reversed OMB's proposal, thereby preventing further staff cuts. The Chairman and Ranking Minority member of the Committee on Aging led a group of Senators in writing to the President applauding his decision. In view of continued congressional attention on the damaging consequences of cutbacks in staff, further proposals for staff cuts will be met with concern in the White House and on Capitol Hill.

The philosophy guiding the SSA cuts was embodied in the 1983 Grace Commission Report, which recommended that SSA eliminate 17,000 staff positions and close over 800 field offices, based upon the rationale that operating a single large office in a city of 500,000 to 1 million would be cheaper than operating several small offices. Critics pointed out however, that the Grace Commission's rationale rested entirely on cost factors, and failed to assess the effect of closings on the quality of public service.

In 1984, SSA was asked to provide OMB with an estimate of the staff-year savings which could result from an agency computer modernization plan. The agency was fraught with disagreement regarding staff-reduction potentials and key persons were not involved in formulating the recommendation which eventually went forward. According to GAO, "it appears that SSA's inability to reach agreement and respond to requests * * * for staff-year savings and the resulting estimate * * * contributed to SSA's being in an essentially reactive position to OMB's call for a 17,000 staff reduction."

While most critics recognized that SSA needed to monitor its operating costs closely and that some staff reductions and office closings may have been necessary, they nonetheless believe that SSA has been pursuing cost cuts without regard to the quality of service being provided. Congressional testimony and GAO reports continued to reveal in 1989 that severe stress from increasing workloads is contributing to a deterioration of overall staff effectiveness. Critics cited the consequential loss of confidence in the system among younger workers, a declining number of whom plan to make a career of Social Security. Moreover, many older workers state that their only reason for remaining with the agency is to keep their Civil Service retirement benefits. The combination of many employees fast approaching retirement age, along with the SSA's increasing difficulty in retaining a hiring pool of younger, lower level employees, threatens the future effectiveness of the agency.

Dr. Arthur Flemming, former Secretary of the Department of Health, Education, and Welfare, has expressed concern that this problem could have severe repercussions, especially given the rapid aging of the American work force. According to Dr. Flemming, morale problems within SSA are so severe that we stand to witness a deterioration in the calibre of SSA personnel at just the time when the burdens become heavier. Commissioner King acted upon these concerns in 1989, and worked to stop a trend toward the dissipation of staff and the deterioration of services at SSA.

(3) Nationwide Toll-Free Number

On October 1, 1988, SSA launched a toll-free telephone system throughout 60 percent of the Nation that bypassed the agency's network of local Social Security field offices. From that point on, in any area under the system all calls to local Social Security offices were re-routed to a small number of teleservice centers. Despite a number of serious problems with the system and persistent Congressional criticism, a year later the toll-free line went into effect throughout the entire country.

During the first year of operation, many callers to SSA's toll-free line frequently were unable to get through or to obtain accurate information when they did. A hearing of the Senate Special Committee on Aging in March 1989 revealed that in January of that year the busy signal rate was about 43 percent nationwide, and in a number of metropolitan areas it was as high as 60–70 percent. The hearing uncovered survey results showing that nearly one in four callers was given the wrong answer to questions about Supplemental Security Income (SSI).

With respect to the high busy signal rate, a GAO study conducted before the implementation of the toll-free system at the request of Senator David Pryor outlined a number of special steps SSA claimed that it was going to take to avoid this problem. Among them, the agency stated that it would carefully limit the promotion of the new toll-free line and work closely with aging advocacy groups to ensure that they did not over-sell the number.

Amid growing Congressional criticism of the toll-free system, SSA began detailing staff out of Social Security field offices and into the teleservice centers to help answer calls. According to GAO, some of these staff were unqualified to do so, while the accompanying drain on field staff jeopardized the ability of those offices to serve the public. GAO also concluded that studies SSA presented at the Aging Committee hearing showing very low error rates were not methodologically sound and were, therefore, inconclusive.

From the start, SSA aggressively promoted the new service throughout the Nation as giving "the public one more option—for many, the most convenient option—of doing business with SSA." Critics of the new system, however, contended that this was misleading because under the new system the public lost the ability to contact their local Social Security field office.

When callers of the toll-free line realize that they can no longer speak with staff in their local SSA office, many are upset and reluctant to discuss their financial affairs with a stranger. Moreover, as Senator Burdick pointed out at the Aging Committee hearing, callers can not reach the same person twice over the toll-free line when a problem arises that requires more than one call to settle.

There is also a concern that callers may be given wrong information as a result of their call being handled out of State. For example, individuals with questions about their State's SSI supplementation rate may be given the rate for the State in which their call is taken rather than made. At a hearing of the House Select Committee on Aging a SSA teleservice employee testified that many Spanish-speaking callers from the West Coast were being routed to her Pennsylvania teleservice center without regard to the lack of bilingual capability at that site.

In defense of the new toll-free line, SSA contended that the overwhelming number of calls were evidence of its popularity and the public's implicit approval of the teleservice system. In response, critics pointed to the agency's aggressive promotion of the service and the fact that those in need of assistance from SSA have no choice but to call the toll-free line.

A more long-term concern examined at the Senate Aging Committee hearing was SSA's plan to make the toll-free line the "predominate mode" of service in coming years. Known as Project 2000, SSA's plan also would employ voice-activated answering systems in place of human beings.

Aging Committee Chairman David Pryor and a number of representatives of aging advocacy organizations expressed strong opposition to the depersonalized vision outlined in Project 2000. They emphasized that this approach was incompatible with SSA's mission to serve those who are highly vulnerable, who often need the one-on-one service to be fully responsive, and who frequently are intimidated by modern technology.

The new SSA Commissioner, Gwendolyn King, has distanced the agency from Project 2000, particularly with regard to the plan's proposal to dehumanize services. Despite concerted efforts to improve the toll-free line, however, problems of poor accessibility flared repeatedly throughout 1989 and into 1990. In the first week of January 1990, for example, three out of every four callers were unable to get through on the toll-free line. Although a traditionally busy time for the agency, similar episodes occurred in the preceding months. In the absence of improvement, continued congressional oversight and concern over the new toll-free service can be expected.

(4) Computer Modernization

Although SSA was once a leader in using automation to improve its operations, the last 10 to 15 years have seen its computer systems deteriorate to the brink of disaster. In the early 1980's, this deterioration affected virtually every aspect of SSA's operations, including its organization, management, personnel, and ability to serve the public. In the past decade SSA has made three attempts to upgrade its computer operations, none of which have been completely successful. The current effort, known as the Systems Modernization Plan (SMP), began in 1982. The SMP was to involve an effort to improve four major advanced data processing areas at the agency: (1) Software and software engineering; (2) hardware, and therefore SSA's capacity; (3) data communications utility; and (4) database integration. The main thrust of this modernization effort was software improvement.

In late 1989, a crisis demonstrated that SSA still has far to go to successfully achieve its systems modernization goals. On November 22, Congress repealed the Medicare Catastrophic Coverage Act, requiring that premiums no longer be deducted from Medicare beneficiaries' Social Security checks. SSA predicted it would not be able to stop charging catastrophic premiums for 5 or 6 months, which meant that nearly 33 million retirees would be overcharged $5.30 a month. Like a runaway train, SSA's computers could not be reprogrammed more quickly to avoid the overcharges. Aging Committee Chairman Pryor wrote to Commissioner King to request that the overcharges be halted as soon as possible. At the same time, Senators Heinz and Pryor wrote to GAO requesting a study of SSA's efforts to stop withholding premiums. King assembled a panel of experts, and based on their advice, the Treasury Department planned to issue separate bimonthly refund checks while SSA was reprogramming its computers. Although this solution assisted Medicare beneficiaries to get faster refunds, it added to the Government's expense and increased SSA's overall workload on the project. This episode demonstrated that improvements remain to be made before SSA's computer system meets its promises.

While the SMP was originally designed as a 5-year modernization effort (1982–87), the project remains to be finalized. The design, testing, and implementation of the computer system will not be completed until some time in the 1990's. According to GAO, this will result in delaying much needed improvements in SSA's existing post-entitlement system.

It is important to note that SSA has made significant progress in certain areas of its modernization plan, including considerable hardware improvements and some software improvements. However, the agency has been criticized for hastily purchasing new hardware before its future needs were fully understood. In addition, crucial software modernization has been sluggish.

SSA's problems have consistently involved inefficient management and organization, as well as a lack of planning for the future. Efforts to improve these inadequacies will take time, especially when considering the continuing threat of administrative budget cuts. However, faced with continued congressional scrutiny, SSA will likely continue improving its modernization effort.

(5) SSA as an Independent Agency

In 1989, the concept of making SSA an independent agency proceeded further than ever before. Differing proposals to accomplish the same end were approved by the House and the Senate Finance Committee and headed toward rapid enactment. Instead, as with so many other proposals, it was dropped from the final version of the reconciliation bill in response to the movement to strip the bill of "extraneous" material. Despite this progress, large differences remained between the House and Senate versions, and the administration remained intensely opposed to the idea, with top officials threatening to recommend that the President veto any proposal to make SSA independent. The stage was set for further consideration of the idea in 1990.

Social Security's inclusion in the Federal budget beginning in the early 1970's magnified the visibility of its impact on national fiscal policy. The creation of the unified Federal budget sparked proposals for Social Security cutbacks by the Nixon, Ford, and Carter administrations. These propositions served as an incubator for a movement to create an independent Social Security agency. Calls for agency independence increased when, during the early 1980's, Social Security funds were repeatedly mentioned as a means toward balancing the Federal budget.

During the past two decades, many have argued that SSA's administrative performance would be improved if it were established as a separate agency, independent of the Department of Health and Human Services (DHHS). In its March 1981 recommendations, the National Commission on Social Security endorsed the establishment of an independent agency, as did a majority of the members of the 1983 National Commission on Social Security Reform. Many have recommended that a bipartisan board manage and oversee Social Security, as was the case in the first decade of the program—1935–46. Advocates of an independent agency often cite the need for continuous, consistent leadership in Social Security, which is needed to improve long-term management and effectiveness of the agency, and believe that independence is a means toward that end. They argue that Social Security, as an entitlement program, should be shielded from short-term partisan politics and bureaucratic infighting, and that administrative independence would enhance public confidence in the program. Critics maintain that administrative independence does little by itself to ensure continuity of leadership or to insulate the agency from politics.

The 1983 Social Security amendments, in keeping with the National Commission's recommendation on agency independence, authorized the establishment of the Congressional Panel on Social Security Organization. The panel was instructed to identify an appropriate method for removing the SSA from DHHS and establishing SSA as an independent agency, with its own administrative structure and responsibilities.

The panel recommended to Congress that an independent SSA should be headed by a single Administrator, appointed by the President, with the advice and consent of the Senate, to a statutory 4-year term. It suggested that SSA be responsible for the OASDI and SSI programs only, exclusive of Medicare or Medicaid. To lead the agency, it proposed establishing a permanent, bipartisan advisory board of nine members—five appointed by the President, two by the Senate, and two by the House—to oversee the program and make policy recommendations to the Administrator, the President, and Congress.

Sponsors of independent agency proposals often point out that since 1971, SSA has many different Commissioners and DHHS has had numerous Secretaries. SSA has been administratively reorganized a number of times in the past decade, resulting in little continuity or long-term coherence in leadership and policy. Ironically, they propose as a cure a proposal to reorganize SSA. Further, advocates point to major policy debacles that have plagued Social Security in the past 5 years, including the crisis in the DI program created by the overzealous implementation of continuing disability reviews, and the retroactive elimination, and subsequent restoration of the minimum benefit. It is contended that with an independent agency, high level leadership would be more sensitive to the integrity of Social Security, and more effective in promoting sound policy and administration.

Both the House and the Senate Finance Committee independent agency proposals approved in 1989 required SSA to handle only the Social Security and SSI programs, leaving Medicare and Medicaid to be handled by DHHS. They differed in that the House proposal had a three-member bipartisan board in charge of SSA, while the Senate Finance Committee proposal recommended a single administrator.

Many opponents of an independent SSA argue that conflicts could arise between board members that could impair the agency's efficiency. They add that most agency problems do not result from SSA's location as a part of DHHS, but are rather the result of poor planning and policymaking. Organizational structure may be less to blame than bad leadership and low morale. Some claim that changing the administrative structure will not by itself eliminate policy problems. Improvements can only be accomplished by appointing intelligent and competent officials, and considering the potential administrative and statutory ramifications of their contributions. Opponents believe that while the creation of an independent SSA might alleviate certain management problems, it could just as easily create others. They maintain that SSA's current administrative problems have not resulted from bureaucratic obstacles imposed by DHHS, the Office of Personnel Management, and the General Services Administration, but rather that those agencies provide valuable oversight contributions, without which problems could be much worse. Some argue that independence would strengthen the hand of the Office of Management and Budget in dominating the agency. Arguments are also made that independence, in and of itself, would not insulate SSA from politics nor insure elimination of the troublesome, frequent turnover of SSA Commissioners. Indeed, Senator Moynihan proposed in 1989 that SSA should be made a Cabinet level agency, despite arguments that such a move could politicize the agency.

Many believe that Social Security's impact on the Federal fiscal policymaking agenda is too important to allow the program to escape difficult fiscal choices. They argue that an independent agency would not, and should not, put Social Security above politics and that an independent Social Security Administration would not exist in a political and philosophical void. A board appointed by the President and confirmed by the Senate would not necessarily be politically neutral, nor would a single administrator. It is precisely this type of political influence that advocates of an independent agency seek to avoid. They argue that independence would insulate Social Security programs from short-term fiscai policy decisions that could prove detrimental to the program's long-term efficiency. Others, however, assert that by establishing an independent tribunal with diminished accountability to the President, Social Security would be less accountable to the views of the public, and less subject to reform or revision should that become desirable in the future.

In 1989, the Chairman of the Aging Committee requested a study by the GAO and another by the National Academy of Public Administration to examine how to structure the leadership of an independent SSA. Both GAO and Harold Seidman, who authored the National Academy of Public Administration study, strongly recommended that a single administrator be appointed rather than a board.

According to GAO, the idea of an independent SSA presents both advantages and disadvantages. GAO believes that independence could enhance the stature of the Commissioner, thereby attracting highly qualified individuals to the job. Such conditions could indeed enhance policymaking and leadership continuity. However, GAO is troubled by the potentially detrimental effects of establishing a governing board. In supporting this position, the agency cites frequent criticisms of the effectiveness of similar boards, including: (1) Untimely decisions; (2) interference by board members in the daily operations of the agency; and (3) diffused accountability. GAO believes that confusion could develop regarding whether the President, the Commissioner, or the board would be accountable to Congress and the public. GAO argued that, "in practice, the board form of organization has not proven effective in providing stable leadership, in insulating decisions from political pressures, and in assuring that diverse viewpoints are considered in the decisionmaking process." Although GAO declines to take a position on whether an independent agency is advisable, they do state that "on balance we do not believe that independence of SSA is essential to solving the serious management problems (at SSA). Independence is not the panacea."

The Aging Committee also requested a study performed under the auspices of the National Academy of Public Administration (NAPA), which concluded, like GAO, that a single administrator is a superior form of organization to a board for a large executive agency like SSA. Seidman, writing for NAPA, observed, "given the difficulty of maintaining a clear dividing line between policy and administration, few boards are willing to delegate responsibility for day-to-day management and operations to a chief executive officer or to refrain from micromanaging." Decrying organizational responses to management and policy problems, Seidman wrote, "In the final analysis, public confidence in a government agency is determined by what it does, not by how it is organized." Former Commissioner Robert M. Ball in a separate statement issued under the same study by NAPA argued for a board form of organization. While conceding that "if all that were at issue was the efficiency of day-to-day operations, it is probably true that a single head would be a slightly better form of organization," Ball argued that the board was needed to give SSA the appearance of being above politics, "to underline the long-range character and trustee nature of the government's responsibility." He also argued that a board would help prevent abrupt shifts in policy that might lead to undermining confidence in the program.

Advocates of an independent SSA are likely to push for its enactment in 1990, although it is as of yet unclear how this can be accomplished given the fierce opposition of the administration. It may have been difficult for the President to have vetoed the budget reconciliation bill in 1989, but if an independent SSA proposal is contained on another vehicle which is not a "must-pass" bill, the President could more easily veto it. It is not yet clear whether an appropriate vehicle for enacting this legislation will present itself in 1990.

(6) Services Improvements

Problems over the past years at SSA have resulted in a significant increase in complaints received by Congress on the quality of service provided to the public by SSA. Constituent dissatisfaction has been voiced with respect to the ability to get questions answered quickly and correctly; the ability to recontact the same staff person who responded to an individual previously; the ability to file an application easily and quickly, and to have SSA promptly process changes in eligibility status without loss of benefits; and the ability to gain direct access to field office experts.

To remedy service problems, Congress enacted significant portions of companion bills introduced by Senator Donald W. Riegle and Representative Sander Levin to improve SSA services as part of OBRA 1989 (P.L. 101-239). These changes require SSA to: (1) Improve notices to the blind and study the need for additional notices improvements; (2) ensure that timely interviews are provided to visitors to local SSA offices who have time sensitive problems; (3) provide recourse to claimants and beneficiaries who lose benefits because of inaccurate or incomplete information provided by SSA; (4) provide additional time to correct errors in individual earning records; and (5) consider a person's limitations (physical, mental, educational, and language) in determining whether a person acted in good faith or was at fault in taking certain actions in dealing with SSA.

Other service improvements, largely included by the House and the Senate Finance Committee in their respective reconciliation bills, were not enacted in the final version of OBRA 1989. They will be promoted in the House and the Senate in 1990. They include additional notice improvements, more reasonable ways to collect overpayments without causing financial hardship, assistance to the homeless, and telephone service center accountability for the information they provide. SSA is being urged to make these improvements on an administrative basis without waiting for additional legislation.

(7) Representative Payees

In 1989, congressional attention focused on abuses occurring under SSA's program to appoint representative payees to handle the finances of beneficiaries determined by SSA to be unable to handle their own finances. The Senate Aging Committee and the House Ways and Means Committee held hearings on the problems, and the House approved a significant package of representative payee reforms. Chairman Pryor introduced a bill, S. 1130, which also proposed a comprehensive reform of SSA's representative payee system. Although most of S. 1130 was approved by the Finance Committee, it was not included in the final budget reconciliation package. Given the movement on this issue in both the House and the Senate, and the similarity of their proposals on this issue, serious attention will be paid to these proposals in 1990.

The Senate Finance Committee approved a series of reforms closely corresponding to S. 1130. Its proposal strengthened the requirement for SSA to investigate payees and to monitor their performance, with special attention to high-risk categories of payees. New recordkeeping would be required to assess whether individuals were serving as payees for multiple beneficiaries and whether individuals appointed as payees had previously been suspended for inadequate performance or convicted of Social Security fraud. Creditors were barred in most cases from serving as payees, and provisions were included to help beneficiaries find suitable noncreditors to serve as payees. SSA would be prevented from suspending benefits from most beneficiaries who are unable to find a payee, and SSA would be liable to repay stolen benefits if its staff had not properly followed guidelines designed to prevent misuse of funds. Organizations would be allowed to charge a small fee to serve as payee for individuals without a family member or close associate to fill that role.

The House of Representatives approved a similar, although in some areas less far-reaching, series of reforms in the representative payee system. Both House and Senate moved in the same direction motivated by the same concerns for vulnerable beneficiaries and perceived deficiencies in SSA's conduct of the program. SSA testified that it was taking administrative steps to improve payee oversight, and even moved independently to initiate some of the reforms proposed in Congress. With this issue at the top of the agenda for both House and Senate committees, and a workable compromise in sight, legislative action is likely to produce results in 1990.

(8) Privacy and Nondisclosure of Confidential Information

In 1990, under pressure by the Senate Aging Committee, SSA ended its policy of verifying Social Security numbers for commercial companies, including those that check credit ratings. The Chairman of the Aging Committee had learned in April 1989, that SSA had been operating a program to verify Social Security numbers in the files of private companies. Chairman Pryor requested that the American Law Division of the Congressional Research Service conduct a study of the legality of the program. CRS concluded that the program was illegal under the Privacy Act of 1974. Other experts agreed.

At an April 10, 1989, hearing of the Aging Committee, Chairman Pryor asked then-SSA Commissioner Dorcas Hardy about the program. Hardy at first denied the agency had made such verifications, in particular for the TRW Credit Services company. Upon being presented with documentary evidence by Chairman Pryor, Hardy admitted that verifications had been done for private companies, including TRW.

Concerned about factual mistakes in the testimony of Commissioner Hardy at the hearing, Chairman Pryor then wrote Secretary of Health and Human Services, Louis W. Sullivan, M.D., to request an investigation. Although the Secretary responded that he believed such an investigation unnecessary, an examination was eventually conducted by the DHHS Inspector General's office which confirmed the assessment provided to the Aging Committee by SSA subsequent to the hearing as to what had occurred in the verification program. Specifically, 3,277,430 verifications were done for private companies. Congressional opposition to such a program rapidly intensified after it was uncovered and widely publicized. Less than 1 week after the negative verification program had been revealed at the Senate Aging Committee hearing, Hardy ended the policy which had permitted it.

Given the intensity of public and congressional opposition to allowing private companies access to confidential Government held information, and the illegality of such access, a program similar to the one conducted in the 1980's is highly unlikely to be revived.

(D) BENEFIT ISSUES AND LEGISLATIVE RESPONSES

Social Security has a complex system of determining benefit levels for the millions of Americans who currently receive them, and for all who will receive them in the future. Over time, this benefit structure has evolved, with Congress mandating changes when it believed they were necessary. A number of specific benefit issues drew the attention of Congress in 1989, including the Social Security earnings test, the "Notch," and a revised consumer price index for the elderly.

(1) Social Security Earnings Test

One of the most controversial issues in the Social Security Program is the earnings test, which is a provision in the law that reduces OASDI benefits of beneficiaries who earn income from work above a certain sum. Debate over the Social Security earnings test intensified in 1989, with floor action in the Senate and proposals emerging from the Senate Finance and Ways and Means Committees in their respective budget reconciliation bills. Although the provisions were not included in the enacted version of the reconciliation bill because they were stripped in conference committee, liberalization of the earnings test remains high on the Social Security agenda for 1990.

In 1989, Social Security beneficiaries aged 65 to 69 had their benefits reduced by $1 for every $2 earned above $8,880, rising to $9,360 in 1990. For those between age 62 and 65, the earnings limitation was set in 1989 at $6,480, rising to $6,840 in 1990. Beginning in 1990, beneficiaries aged 65 to 69 will have benefits reduced $1 for each $3 earned above $9,360. The exempt amounts are adjusted each year to rise in proportion to average wages in the economy. The test does not apply to beneficiaries who have reached age 70.

The earnings test is among the least popular features of Social Security. This benefit reduction is widely viewed as a disincentive to continued work efforts by older workers. Indeed, many believe that the earnings test penalizes those aged 62 to 69 who wish to remain in the work force. Once workers reach age 70, they are not subject to the test. Opponents of the earnings test consider it an oppressive tax that can add 50 percent to the effective tax rate workers pay on earnings above the exempt amounts. Opponents also maintain that it discriminates against the skilled, and therefore more highly paid, worker and that it can hurt elderly individuals who need to work to supplement meager Social Security benefits. They argue that although the test reduces Federal budget outlays, it also denies to the Nation valuable potential contributions of older, more experienced workers. Some point out that no such limit exists when the additional income is from pensions, interest, dividends, or capital gains, and that it is unfair to single out those who wish to continue working. Finally, some object that it is very complex and costly to administer.

Defenders of the earnings test say it reasonably executes the purpose of the Social Security Program. Because the system is a form of social insurance that protects workers from loss of income due to the retirement, death, or disability of the worker, they consider it appropriate to withhold benefits from workers who show by their substantial earnings that they have not in fact "retired." They also argue that eliminating or liberalizing the test would primarily help relatively better-off individuals who need the help least. Furthermore, they point out that eliminating the earnings test would be extremely expensive. They find it difficult to justify draining the Federal budget by an additional $57 billion over 5 years in order to finance the test's immediate removal. Proponents of elimination counter that older Americans who remain in the work force persist in making contributions to the national economy and continue paying Social Security taxes.

In 1989, perennial proposals to liberalize or eliminate the earnings test were suddenly thrust to the forefront of congressional attention. In 1989, the House included a proposal to increase the exempt amounts by $360 in 1990 and $600 in 1991 for individuals aged 65–69 as part of its 1990 Omnibus Budget Reconciliation bill. The Senate Finance Committee included an even greater liberalization of the test in markup of its reconciliation bill. The provision would have raised the limit by $2,340 in 1990 and a similar amount in 1991, for a total increase of roughly $5,000 over current law for those aged 65–69; in addition, it would have decreased their benefit reduction rate on the first $5,000 in earnings above the exempt amount to $1 for every $4 in earnings. The proposal was later dropped from the Senate bill as part of the bipartisan agreement to limit the bill to items that reduce spending, and no provision was included in the enacted version. The Senate earlier had approved an amendment by Senator Bentsen on S. 5, a child care bill, that would have raised the exempt amount by $1,200 for this age group, as well as decreasing the reduction on the first $5,000 above the exempt to $1 for every $4 earned.

Despite this intense legislative activity, no earnings test measures were enacted in the final version of any bills. Yet because both bodies approved some form of a change, action is expected next year. Given the high cost of entirely eliminating the earnings test, serious legislative initiatives will continue to propose compromises.

(2) The Social Security "Notch"

The Social Security notch refers to the difference in monthly Social Security benefits between some of those born before 1916 and those born from 1917 to 1921. The difference arises from changes in the benefit formula contained in legislation enacted in 1972 and 1977. Differences are substantial primarily for those in the highest benefit levels who defer retirement until age 65.

The Social Security notch stems from a series of legislative changes made in the Social Security benefit formula, beginning in 1972. That year, Congress first mandated automatic annual indexing of both the formula to compute initial benefits at retirement and of benefit amounts after retirement, known as COLA's or cost-of-living adjustments. The intent was to eliminate the need for ad hoc benefit increases and to adjust benefit levels in relation to changes in the cost of living. However, the method of indexing the formula was flawed in that initial benefit levels were being indexed twice—for increases in both prices and wages. Consequently, initial benefit levels were rising rapidly in relation to the pre-retirement income of beneficiaries. Prior to the effective date of the 1972 amendments, Social Security replaced 38 percent of pre-retirement income for an average worker retiring at age 65. The error in the 1972 amendments, however, caused an escalation of the replacement rate to 55 percent for that same worker.

Without a change in the law, by the turn of the century, benefits would have exceeded a recipient's pre-retirement income. Financing this increase rather than correcting the overindexing of benefits would have entailed doubling the Social Security tax rate. Concern over the program's solvency provided a major impetus for the 1977 Social Security amendments, which substantially changed the benefit computation for those born after 1916. To remedy the problem, Congress chose to partially scale back the increase in relative benefits for those born from 1917 to 1921 and finance the remaining benefit increase with a series of scheduled tax increases. Future benefits for the average worker under the new formula were set at 42 percent of pre-retirement income.

The intent of the 1977 legislation was to create a relatively smooth transition between those retiring under the old method and those retiring under the new method. Unfortunately, high inflation in the late seventies and early eighties caused an exaggerated difference between the benefit levels of many of those born prior to 1917 and those born later.

Although the notch is actually the result of an overindexation of benefits for those retiring under the old formula, and does not reflect any reduction in real benefits to those retiring under transition rules, it has been perceived as a benefit reduction by those affected. Those born from 1917 to 1921—the so-called notch babies—have been the most vocal supporters of a "correction," yet these beneficiaries fare much better than those born later. Individual Members of Congress have responded to the notch-babies' complaints by introducing a series of proposals for relief, most of which would give benefit increases to those born after 1916.

At a January 1989 hearing of the Senate Finance Subcommittee on Social Security, studies were examined that dealt a severe blow to arguments of unfairness leveled by the notch movement. The GAO testified on a March 1988 GAO report entitled "Social Security: The Notch Issue." The report traces the origin to the overindexing of the benefits for those born in the period preceding the notch years. Although no position is taken with respect to legislation to compensate notch beneficiaries, the report characterizes these proposals as costly—ranging from $20 billion to $300 billion—and possibly difficult to administer. Assuming the financing of the additional benefits would come from the Social Security trust funds, the ability of the Social Security to withstand any economic downturns and to provide benefits from future retirees would be jeopardized.

Also testifying on a recent study with similar findings was the National Academy of Social Insurance (NASI), a nonprofit, nonpartisan organization focusing on Social Security and related issues. Robert Meyers, former chief actuary of the SSA and current chair of the NASI study panel, summarized the study's conclusion: "the real problem with regard to this matter is that those persons born before 1917 who worked beyond age 62 after 1978 receive undue windfalls. Those born after 1916 are equitably treated, consistent with the intent of Congress, and receive proper benefit amounts. . . . There is no reason why younger workers should, over the years, pay more taxes to provide windfall benefits to this group." The panel therefore recommended that no legislative action be taken on the notch benefit issue.

Drawing on these reports, the chairmen of the House and the Senate Social Security subcommittees, Representative Jacobs and Senator Moynihan, respectively, have gone on record as opposing notch legislation. Nevertheless, the notch babies have thus far not been dissuaded from their campaign to receive compensation for what they passionately contend is unfair treatment. As a result, controversy is continuing and bills have been introduced in the 101st Congress.

(3) Consumer Price Index Reform

The Federal CPI measures the average U.S. inflation rate. The CPI's importance to older Americans stems from its use in determining COLAs for Social Security and other Federal retirement and disability programs. The first Federal CPI was developed during World War I. Since then, the CPI has undergone numerous modifications, resulting in the inflation index which is currently in place.

In 1972, Congress amended the Social Security Act to provide for automatic, annual COLAs, linking them to changes in the CPI. It was believed that indexing benefits in this manner, rather than providing for ad hoc increases, would more effectively maintain the value of the retirement income of older Americans. In 1989, Social Security and SSI beneficiaries received a 4 percent COLA; in 1990 the COLA was 4.7 percent.

When automatic COLAs were first mandated, a single CPI was in existence. That index represented the price of goods and services purchased by urban wage earners and clerical workers, and did not (and does not) survey retirees. In 1978, however, a new index known as the CPIu was developed. The new index measured the goods and services purchased by all urban consumers, including white/blue collar workers, the unemployed, and retirees. Whereas the old CPI, redesignated as the CPIw, is representative of approximately 32 percent of the population, the CPIu is reflective of about 80 percent of the population, including the elderly.

At a 1988 Senate Aging Committee hearing on the advisability of replacing the CPIw with the CPIu, Bureau of Labor Statistics Commissioner Janet Norwood noted that "Social Security recipients have expenditure patterns most like older consumers and more similar to those of the CPIu households than to those of the CPIw." At the same hearing, as well as in a 1982 report, the General Accounting Office recommended using the CPIu for COLA calculations. The Office of Management and Budget, which made this same recommendation in 1980, subsequently opposed the proposed change due to cost and other considerations, and they were never implemented.

In 1989, Aging Committee Chairman David Pryor introduced S. 864, with the cosponsorship of Senators Heinz, Pressler, and Burdick, to require that the CPIu be used in place of the CPIw for the indexation of Social Security benefits and other Federal retirement and disability programs. That legislation was pending at the end of 1989.

(E) SOCIAL SECURITY PAYROLL TAX ISSUES

(1) Social Security Payroll Tax Rates

On December 29, 1990, Senator Moynihan proposed to reduce Social Security payroll taxes by $55 billion in 1991 and corresponding amounts in later years, thereby moving the Social Security system closer to pay-as-you-go financing. His proposal would repeal the January 1, 1990, increase to 6.2 percent from 6.06 percent. The plan would reduce the tax to 5.1 percent in 1991. Moynihan called for an end to the practice of using trust fund surpluses to finance the budget deficit. While the outcome of the proposal is yet unclear, it sparked the most heated and widespread debate about Social Security financing since the 1983 amendments.

The Bush Administration strongly opposed the tax cut plan, proposing instead to retain Social Security revenues and outlays in the Gramm-Rudman deficit calculations while using Social Security surpluses amassed after 1993 to retire publicly held national debt. The administration's plan would phase in over a 4-year period. In 1993, the on-budget outlay used to retire the national debt would equal 15 percent of the surplus in that amount, rising to 100 percent by 1996.

In early 1990, the chairman of the Senate Budget Committee proposed to tie cuts in Social Security taxes to deficit reduction targets. Chairman Jim Sasser's proposal would replace the Gramm-Rudman penalty of a sequester in the event Congress fails to reach deficit targets with the reward of a rollback of Social Security taxes when Congress reaches the new targets set in his proposal.

Whatever the outcome of these proposals, which promise to become entangled in debates over national budget and tax policies, they promise to set the tone for a high level and high profile discussion over the fate of reserve financing for Social Security.

(2) Social Security Payroll Tax Base

One of the key legislative developments in 1989 was an expansion of the Social Security tax base aimed at helping Congress reach the fiscal year 1990 Gramm-Rudman deficit reduction targets, enacted as part of the OBRA 1989 (P.L. 101-239). Despite public commitments made by congressional leaders in both parties to take Social Security out of deficit reduction accounting games, a provision was included quietly in the final hours of the 1989 budget process that essentially increased collection of Social Security taxes in order to finance the deficit. The provision was expected to raise $4.8 billion over a 5-year period, of which only $231 million is designated in the bill to be spent of Social Security programs. The rest goes to hide the true size of the deficit. Ironically, the provision is expected to cost the OASDI trust funds a significant amount in latter years, slightly worsening the existing deficit in long range financing for the Social Security programs.

The change affects the definition of wages, or how to count the deferred compensation that some people shelter from income taxes by putting aside income in what are called 401(k) and certain other retirement accounts. The Social Security taxable earnings base, the benefit formula, and other program amounts are increased each year in accordance with the increase in the average total wages in the economy. Before the change, total wages were defined to be those that are reported for income tax purposes. Since various forms of deferred compensation are not subject to income tax at the time of the deferral, they have not been calculated in averaging wages for Social Security purposes. Under the new law, deferred compensation is included in measuring the annual increase in average wages.

The provision effectively increases the amount of income subject to Social Security taxes by an additional 2 percent, or $900 in 1990. In 1990, the taxable maximum already had been scheduled to rise from $48,000 to $50,400. With the expanded definition of the wage base, it will go up to $51,300 in 1990. Although Social Security payroll taxes will rise by about 2 percent for around 10 million of the Nation's top wage earners, they will eventually receive higher benefits as a result of their higher contributions to the program. This accounts for the long-term cost of the provision to the trust funds.

The provision is a classic example of the budget fiction that congressional leaders decried when they vowed to take Social Security reserves out of the Gramm-Rudman deficit calculations. Although the $4.8 billion raised by the provision in the first 5 years is used to meet Gramm-Rudman targets, in fact all of the money raised goes into the dedicated Social Security trust funds. Eventually, the funds will be needed to pay higher benefits that will be due to future retirees because of the provision. In other words, no real deficit reduction occurs from the provision. It merely uses the Social Security tax base and trust funds to finance the current deficit, with future generations being asked to pay the real price for today's spending.

Another issue is raised by using the provision to fund the deficit because Senator Bentsen, chairman of the Senate Committee on Finance, had proposed to use the funds to finance a liberalization of the Social Security earnings test. With the deferred compensation revenue no longer available, the task of finding funds to offset the cost of the earnings limit change is made more difficult.

The night the budget reconciliation bill was considered on the Senate floor, Senator Heinz made a strong statement protesting the use of the $4.8 billion for deficit reduction when the funds were going to be used to offset the Social Security retirement test increase. But unfortunately, the deferred compensation question had already been settled in conference.

B. SOCIAL SECURITY DISABILITY INSURANCE

1. Background

During 1989, Congress continued its supervision of SSA's implementation of the reforms intended by the Social Security Disability Reform Act of 1984 (P.L. 98-460). Historically, the Aging Committee has scrutinized the standards and the process used by SSA in reviewing the eligibility status of SSDI beneficiaries. In the mid-1980's, Senator Heinz, as chairman, conducted a series of hearings on the so-called continuing disability reviews. In 1989, an impressive series of legislative reforms affecting SSDI were approved by the authorizing congressional committees in their deliberations over the OBRA 1989. Some important legislation was enacted but many reforms were not included in the final deficit reduction bill because of a bipartisan agreement to minimize items not related to deficit reduction.

Chairman Pryor in 1989 sought to ensure that citizens seeking disability, old age and survivors benefits, supplemental security income, and Medicare had access to fair, impartial hearings with administrative due process designed to improve the management of the hearings and appeals process at the SSA. He introduced a package of bills to protect the rights of claimants for Social Security benefits and to ensure that if necessary, their cases are strongly represented at fair, impartial, and speedy hearings.

(A) RECENT HISTORY

Since the inception of SSDI, SSA determined the eligibility of beneficiaries. In response to the concern that SSA was not adequately monitoring continued eligibility, Congress included a requirement in the 1980 Social Security amendments that SSA review the eligibility of nonpermanently disabled beneficiaries at least once every 3 years. The purpose of the continuing disability reviews (CDRs) was to terminate benefits to recipients who were no longer disabled.

The new law was to go into effect in 1982. However, on its own initiative in early 1981, SSA accelerated the implementation of the reviews, increasing its monthly review workload by an additional 30,000 cases. As a result, between March 1981 and April 1984, 1.2 million case reviews were completed and close to 500,000 beneficiaries were determined no longer eligible for DI benefits.

Not long after the CDRs were implemented, widespread concern arose about the quality, accuracy, and fairness of the reviews. Many States, on their own initiative or by court order, declared moratoria on the reviews, or began administering the CDRs under guidelines that differed from SSA's official policy. By 1984, more than half the States were either not processing CDRs, or were doing so under modified standards.

In that same year, after extensive hearings and debate over numerous competing proposals, Congress enacted the 1984 Social Security Disability Benefits Reform Act to restore order, fairness, and national uniformity to the SSDI program. The main reform was to require that SSA prove a beneficiary's medical condition had improved from the time of the initial disability determination. Under that mandate, SSA promulgated three major sets of administrative regulations the following year. These rules created new standards for evaluating disabilities caused by mental impairments, created guidelines for the determination of medical improvement as a prerequisite to the termination of benefits, and revised the medical criteria applicable to the determination of a physical disability.

2. Issues and Legislative Response

(A) EXTENSION OF INTERIM BENEFITS

Since 1983, a SSDI beneficiary who has been determined to be no longer disabled has been able to elect to continue receiving benefits, and thus medical care under Medicare, while appealing his or her case before SSA's administrative appeals system. Each year, SSA reviews the cases of thousands of disabled workers. A significant number of these reviews yield adverse decisions, many of which are appealed and ultimately reversed. If the earlier unfavorable determinations are upheld by an Administrative Law Judge (ALJ), the benefits are subject to recovery by SSA.

A provision permitting the payment of benefits upon appeal through the hearing stage was authorized on a temporary basis, in 1983 and has been continually extended since then. The provision was due to expire on December 31, 1989, but was extended for 1 year by the OBRA 1989 (P.L. 101-239). Although the House bill had proposed making the provision permanent, the conference committee only agreed to a 1-year extension. Had the provision not been extended, a decision to terminate benefits at the initial level was to take immediate effect, regardless of whether that decision was later ruled incorrect. Although back payments would be provided in such cases, the absence of benefits in the interim would pose a severe hardship on many disabled workers and their families.

Prior to the 1983 law authorizing interim payments, hundreds of thousands of disabled persons abruptly found themselves without any means of support or medical care as a result of the unprecedented number of SSDI terminations in the early eighties. Originally mandated for 1 year, in 1984, Congress extended the interim authority through 1987 as part of the reform law. Congress extended the provision in 1987 and again in 1988. Given this congressional support for the provision, and its crucial importance to the fairness of the SSDI program, Congress is likely to either continue renewing or making it permanent.

(B) ATTORNEY FEES

The issue of Social Security attorney fees had been engulfed by controversy over the past few years. In 1989, Chairman Pryor introduced a bill, S. 1570, that was designed to take a consensus approach to resolving the issue by streamlining the process for awarding fees to attorneys in Social Security cases. It was approved in 1989 by the Senate Finance Committee in its markup of the budget reconciliation bill, but not included in the final package.

From the standpoint of a disabled worker, severe mental or physical conditions can make a complex adjudicative process especially intimidating and confusing. Not surprisingly, disability claimants are increasingly turning to attorneys for assistance. Currently, about two-thirds of claimants appealing decisions to an ALJ are represented by attorneys.

Underlying the issue of attorney fees is the challenge of ensuring adequate safeguards against overcharges while providing fair compensation for services performed on behalf of the claimant. Disability attorneys and SSA agree that the current payment system is cumbersome, drawn out, and in need of reform. S. 1570 was designed to balance safeguards against the need for fair compensation, while streamlining the process for awarding fees.

In 1987, a battle over fees ensued between SSA and Social Security attorneys. ALJs have responsibility under current law for reviewing fees charged by attorneys in cases argued before them. On April 1, 1987, a new SSA policy temporarily denied ALJs the authority to approve fee requests above $1,500. Previously, an ALJ could approve fees up to $3,000. The basis for this action, according to SSA, was a report of the Inspector General (IG) which concluded that attorney fees were sometimes excessive and should be lowered to a set rate.

Following the start of the new policy, many SSDI attorneys protested that the new policy would deny them adequate compensation, and that payments would be further delayed and complicated as a result of an additional layer of bureaucracy. They argued that disability claimants would be the ultimate losers because fewer and fewer attorneys would be willing to represent them.

Opposition to the new SSA policy rapidly intensified. The result was enactment of a provision in the OBRA 1987 to rescind the new SSA directive and impose a moratorium until July 1989 on changes to the original payment policy pending the completion and consideration of studies by SSA and GAO.

The GAO report completed pursuant to OBRA 1987 found that generally fees for attorneys were not unreasonable. According to the report, 93 percent of the fee requests up to $3,000 were approved, as was 94 percent of the total amount requested. In most cases, only fee requests exceeding $3,000 were significantly reduced.

However, GAO found that the approval process on average took about 7 months and recommended to SSA a proposal to streamline the process, which SSA has yet to complete. Despite these delays, GAO found that claimants did not have difficulty finding an attorney to represent them. The GAO findings on access, however, are of limited utility since they do not look at different categories of cases where concerns have been raised about the lack of private representation, such as cases in which little or no back award can be expected from which to draw fees. Moreover, GAO's conclusion on access is based on a flawed IG study in which only claimants were interviewed, ignoring the potentially large population who did not appeal because of difficulty in securing representation.

SSA later completed a study, as required by OBRA 1987, which recommended near-total deregulation of the attorney fee process, with a two-party check to the attorney and claimant in each case, which would allow them to work out any arrangement they chose. SSA further proposed that fee disputes be given special scrutiny and that special rules of conduct for representatives appearing before SSA be delineated, in order to ensure that claimants were protected in the process of deregulation.

S. 1570 took both the SSA and GAO study findings into account. It promoted the goal stated in the SSA study to "relieve both the agency and attorneys of a growing administrative burden." Congress remained unprepared, however, to go as far in the direction of deregulation as SSA. Yet it became willing to travel down the same path. Moving in the direction envisaged by the SSA study, S. 1570 drew the line by setting boundaries as to fees that can be presumed to be reasonable and proposed that SSA evaluate each fee that falls outside those boundaries. The bulk of all fees could be automatically approved under the proposal, eliminating a huge and unnecessary workload for attorneys and SSA. Indeed, the Congressional Budget Office estimated the proposal could save SSA $18 million in administrative expenses over 5 years. SSA's report estimated expenditures of $6.9 million in fiscal year 1988 for processing attorney fees, or over 200 direct workyears. Reform efforts would redirect the SSA work force to address growing backlogs of cases which GAO has identified as a major problem.

Under current law, when Social Security beneficiaries are represented by an attorney in pursuing an appeal of an unfavorable decision before the agency, the attorney must have his fee approved by SSA. If the fee is approved, SSA directly makes payments to the attorney out of any past due benefits, but not more than 25 percent of past due benefits.

In cases where the beneficiary's back award is subject to offset for repayment of SSI benefits or State assistance, SSA's current policy is to apply the offset before paying the attorney fee. In practice, this results in many cases where there are no funds left to pay the attorney. Similarly, in cases where no back benefits accrue because interim benefits were paid, or where no benefits accrue per se, such as representative payee disputes, Medicare eligibility, or disputes about overpayments, funds are often unavailable for appropriate fees.

A version of S. 1570 was approved by the Senate Finance Committee in its markup of the OBRA 1989. Although the provision was dropped as part of the bipartisan agreement to strip the bill of nonbudget related items, it pointed in the direction Congress can be expected to take in 1990.

Under the provision approved by the Finance Committee, the fee petition process is eliminated in most cases, and replaced with an automatic fee approval procedure. ALJs' and attorneys' fee processing workload is thereby vastly reduced. The current law requirement that the Secretary determine a "reasonable" fee in each case is replaced by a rebuttable presumption that any contractual agreement entered into between an attorney or other representative and a client is approved automatically by SSA. Exceptions are that SSA will review agreements that either would result in fees that exceed 25 percent of past due benefits or $3,000, or fees that are protested by the claimant, representative, the ALJ, or other decisionmaker. In these exceptional cases, attorneys will be required to submit a fee petition, and SSA ensures that fees are reasonable. The $3,000 limit could be increased by the Secretary of DHHS. To ensure that all claimants can retain representation, the proposal provides for appropriate fees in cases where there is no back award. The provision retained the current law requirement that SSA issue separate checks for the claimant and for the attorney. Each party can negotiate his or her check without delay. Having issued two checks, SSA's fiduciary responsibilities are concluded.

By contrast, a 1987 House-approved provision and the SSA study proposed that the current system be replaced by a single two-party check. Such a policy invites delay and fiduciary problems. A single two-party check invites possible misappropriation of funds, giving unscrupulous attorneys an opportunity to exploit their clients, many of whom are mentally impaired. It also necessitates an ongoing supervisory role for the agency to see that funds have been correctly disbursed, and to intervene if problems arise. Such supervision would require a new bureaucracy to review affidavits from attorneys and from claimants concerning the allocation of funds. In the final analysis, beneficiaries are properly entitled to have benefits sent directly to them.

In 1990, Congress can be expected to act on attorney fee reform. The moratorium on changes imposed by OBRA 1987 has expired, the requested studies have been completed, and a compromise proposal has emerged to forge a consensus. The House of Representatives can be expected to approve a provision similar to its 1987 approved version, and to find a compromise with a Senate proposal that adopts the best characteristics of both bills. Significant public support has mounted promoting both House and Senate efforts on this issue, driving it to the top of Congress' Social Security agenda in 1990.

(C) AN INDEPENDENT APPEALS PROCESS

David Pryor, Chairman of the Aging Committee, introduced a bill in 1989, S. 1571, to ensure the independence of the administrative appeals process within SSA. The bill is designed to ensure the independence of ALJs at SSA so that they remain free to make decisions on Social Security cases without political interference. The bill was intended to structurally prevent the problems of the early 1980's, on which the Aging Committee has built a significant record attesting to an assault on thousands of truly disabled Americans who could not argue their case, and a threat by SSA on the independence of ALJs who sought to correct such abuses.

The independence of the appeals process is at the soul of the Social Security Program. SSA is required to conduct hearings to consider appeals of SSA decisions by claimants for benefits. Hearings are conducted by ALJs, who are located organizationally within the Office of Hearings and Appeals (OHA), headed by an Associate Commissioner who reports to the Commissioner of SSA. S. 1571 is designed to prevent ALJs from being subjected to political pressure to save program dollars at the expense of eligible beneficiaries.

ALJs hear and decide cases arising within the jurisdiction of the DHHS, including Medicare and Social Security. The judges are theoretically organized under a Chief ALJ. The position is not a creation of either statute or regulation, making it an ineffective office. The actual authority resides in the Associate Commissioner and the Deputy Commissioner and to whom the Associate Commissioner reports.

A series of congressional hearings in 1975, 1979, 1981, 1982, 1983, and 1988 on the appeals process at Social Security have documented that bureaucratic interference has sometimes threatened the due process rights of claimants. In 1982, the Aging Committee joined with the Governmental Affairs Committee to hold a field hearing in Fort Smith, AR, which provided evidence that such abuses had been occurring. A problem with the current structure is that responsibility for the entire hearing process is placed upon individual ALJs, but the managerial authority for the program is in the hands of nonlegally trained bureaucrats who have sometimes been insensitive to the rights of claimants. A Federal District Court held that the SSA had an ulterior motive in the continuing disability review program to reduce the payment of claims by ALJs and that judges could have reasonably felt pressured to issue fewer allowance decisions, in the case of *Association of Administrative Law Judges* v. *Heckler*, in 1984.

S. 1571 was adopted by the Senate Finance Committee as part of a proposal it approved to make SSA independent of DHHS. This legislation proposed to replace the current arrangement of the OHA with the appointment of a chief ALJ under a special nonpartisan process to administer hearings and appeals. A chief ALJ would be appointed to administer the hearings and appeals process, reporting directly to the Commissioner of Social Security. The chief ALJ would be appointed by the Secretary pursuant to recommendations made by a special nominations commission established for that purpose. The Secretary would invite the participation of the President of the American Bar Association, the Federal Bar Association, and the Chairman of the Administrative Conference of the United States, or their respective designees, and other such representatives as the Secretary considered appropriate. The nominations commission recommends certain individuals. The Commissioner of Social Security either makes a selection, requests a new list, or is required to explain to Congress the reasons for not doing so. The nominee must have been an ALJ for at least 3 years preceding his appointment. The chief ALJ serves for a fixed term of 5 years and may be removed only pursuant to a finding by the Commissioner of neglect of duty or malfeasance in office.

S. 1571 is now considered a vital component of any proposal to make SSA an independent agency. Any proposal to make SSA independent can be expected to contain provisions to ensure the independence of ALJs and the appeals process. The final outcome can be expected, like S. 1571, to keep the office under SSA, but accorded it greater independence and stature within the agency. Confidence in the appeals system would be increased by placing the process under the operational control of a chief ALJ.

(D) WORK INCENTIVES FOR THE DISABLED

In 1989, a significant shift in the way SSDI beneficiaries are treated increased their incentives to return to work. The definition of disability used for eligibility purposes, which has always been strict, was scheduled to be updated. In addition, a provision was enacted that permitted SSDI beneficiaries to remain in the Medicare Program even after losing SSDI eligibility due to work efforts.

To qualify for disability benefits one must have a severe impairment that is expected to last at least 12 months or result in death, and that prevents the performance of "substantial gainful activity (SGA)." In late 1988, Senator Donald W. Riegle, Jr., led 23 Members of the Senate, including the Chairman and Ranking Minority Member of the Aging Committee, in writing to the Secretary of Health and Human Services (DHHS), asking for an improvement in DHHS' definition of SGA. The definition had remained unchanged for 8 years that anyone earning in excess of $300 a month was performing SGA and therefore not disabled for Social Security purposes. The Senators argued that since this figure had not been updated to take into account growth in average wages, the low level of SGA discouraged Americans with disabilities from returning to work. Individuals earning over the SGA level face an abrupt removal from the benefit rolls, resulting in the loss of all cash benefits after a trial work period (TWP), and ultimately resulting in the loss of badly needed Medicare health insurance.

In 1989, DHHS reviewed the SGA definition and proposed increasing the SGA level to $500 per month and also proposed that a trial work period not be triggered until a person earns more than $200 per month or works more than 40 hours per week. Before implementing the change a TWP has been triggered by earnings in excess of $75 per month or work of more than 15 hours per week. The changes became effective January 1, 1990.

SSDI beneficiaries trying to work face two threats—loss of benefits and perhaps more importantly, the loss of health insurance coverage under Medicare. In many cases, earnings from work, when adequate, can replace the Social Security cash benefits. However, such worker often fails to qualify for employee health benefits because of pre-existing impairments or other factors. To remedy this situation, Senator Riegle introduced and Congress enacted as part of OBRA 1989 major provisions of the Social Security Work Incentives Act of 1989.

The provisions guarantee continued availability to Medicare benefits for SSDI beneficiaries, thereby eliminating a major fear preventing them from attempting to work. All SSDI beneficiaries who would otherwise lose health insurance under Medicare because of continued work despite a disabling impairment will now have the option to buy continued Medicare coverage. Low-income individuals will receive assistance through the Medicaid Program. Former SSDI beneficiaries can elect to pay the Part A hospital premium which currently costs about $2,000 a year, as well as the regular Part B premium, to remain in the program after termination due to earnings. Low-income individuals premiums are subsidized under the Medicaid Program on a sliding-fee scale. OBRA 1989 also extended for 3 years the authority of DHHS to conduct work incentive demonstration projects.

These steps taken in 1989 represent a long-sought-after change in the way we treat Americans with disabilities. Until recently, these Americans have been declared unable to work and were penalized for trying to work. The new trend encourages their return to the work force. The Nation is realizing that integration into the work force of individuals with disabilities provides both economic and societal advantages. Congress will continue to explore and encourage this trend.

(E) DISABILITY DETERMINATION PROCESS

As a part of congressional oversight of the implementation of the 1984 Disability Reform Act, recent GAO reports and documentation compiled by the Senate Aging Committee indicate that there are still serious problems with the disability determination process.

A November 1989, GAO report which was requested by Senator Heinz in 1985 found that 58 percent of denied disability applicants are unable to work. In fact, GAO found that denied applicants who are not working are very similar to those awarded benefits in terms of employment, health, functional capacity, and financial status. The study found that rejected applicants most often reported back problems, while mental and heart problems were the most common disabilities among those receiving benefits. In the report, GAO stated that the survey results, "on the surface, appear to raise some questions as to the accuracy of the Social Security Administration's disability criteria and determination process in judging a disability applicant's ability to work."

Senator Heinz has requested followthrough studies to examine the determination process for the nonworking denied study participants, to investigate if disabled persons are having difficulties accessing SSA field office and telephone services, and to determine why there is a higher proportion of denial in the black population.

In addition, support continues to grow for SSA to conduct face-to-face interviews for certain types of disabilities. An April GAO report issued to Andy Jacobs, Chairman of the House Ways and Means Social Security Subcommittee, recommended that SSA initiate a demonstration project that would review selected categories of claimants at the reconsideration stage. This report found that disabilities such as back disorders, heart conditions, lung disease, diabetes, and anxiety were being reversed 70 to 100 percent of the time at the ALJ level, particularly for persons age 55 to 59.

SSA has stated that they are considering conducting personal disability interviews. In 1984, Congress required SSA to carry out Personal Appearance Demonstration projects in 10 States. The projects were to test the efficacy of face-to-face interviews with claimants by Disability Determination Service (DDS) examiners before they were denied or terminated benefits. These projects were late in getting started, and SSA expects to report on them in February 1990.

Members of Congress have expressed concern that there is not sufficient staff at the DDS's to adequately process disability claims. There is a wide variance in among the States in the percent of disability claims allowed. For the 6-month period ending March 1989, the national allowance rate was 36 percent. Louisiana had the lowest allowance rate at 21 percent, while New Jersey, Massachusetts, and Delaware were the highest at 48 percent.

Staffing levels at State DDS units have experienced periods of increases and reductions over the past 6 years. In 1984–85 during the moratorium on continuing disability reviews, staff was decreased. Staffing levels were increased from 12,943 in 1985 to 13,302 in 1986 primarily in response to the ending of the moratorium. However, according to SSA, the DDS units did not need the allocated number of staff, and reductions have been steadily occurring since 1987. In 1989, DDS staffing levels were 11,634, with a level of 11,303 expected in 1990. During this period of staffing decreases, the number of workloads processed has actually increased. SSA attributes this increase to a concentrated effort to increase productivity and to achieve more consistency among the States, and to an increase in automation. Inadequate staff at the DDS units can result in measures leading to unfair or inaccurate decisions in many cases, thwarting the intention of the 1984 Disability Reform Act.

Another problem facing the disability determination process is SSA's continued use of so-called "self-help" application forms for individuals with disabilities. These applications require individuals to spell out all of the limitations caused by their impairments. Although SSA claims the forms are helpful to claimants, in fact their apparent purpose is to save SSA staff time and the result is that less information is collected and provided to State DDSs for their consideration. An Atlanta SSA regional memo indicated that staff was giving the forms to people who were incapable of completing it, and that one needs a college education to complete the form properly. The memo indicated that SSA was sending individuals with mental disabilities or illiteracy home with the form to complete, without SSA staff assistance in correcting errors.

The Aging Committee will continue to investigate these problems in 1990, and to recommend the elimination of abuses such as self-help applications. Given the growing magnitude of evidence of problems in the disability determination process, increased congressional scrutiny is likely in 1990.

C. PROGNOSIS

The 1983 changes in Social Security financing are widely regarded as having ensured the solvency of the system well into the next century. However, the same law that appears to have restored fiscal health to Social Security also set into motion a rapid build up of reserves that is creating controversy by being used to finance the Federal budget deficit.

In 1990, the removal of Social Security trust funds from the budget will be at the center of congressional attention. Key leaders have reached a consensus about the need to restore truth-in-budgeting. In that debate, questions of national finance, including the obstacles to full deficit reduction, will come to the foreground. Moynihan's proposal to cut Social Security taxes will be debated as Congress confronts how the growing reserves in the trust funds should affect the national savings rate and the Social Security tax structure.

Pressures will mount to enact Social Security reforms in 1990 because many of the positive reforms approved in 1989 by the Ways and Means Committee, the Finance Committee, or both, were stripped during the 1989 budget process. Should the Ways and Means Committee, which under the Constitution initiates Social Security legislation, approve a bill which combines the best elements of the 1989 House and the Senate Finance Committee reconciliation bills, the leadership of the Senate would be inclined to consider and move its own version to conference committee. The Chairman of the Finance Committee will be concerned about continuing the precedent that Finance Committee approved legislation becomes enacted in the same Congress. Institutional patterns dictate the importance of demonstrating that the Chairman can translate committee recommendations into public law. If the Finance and Ways and Means Committee finds a way to move legislation outside the context of budget reconciliation, with the intermediation of public interest groups, 1990 could be a landmark year for Social Security legislation.

Among the key issues left on the burner for 1990 are proposals for earnings test increases, representative payee reforms, reorganizations of SSA as an independent agency with an independent appeals process, attorney fee reform, work incentives for the disabled, SSA services improvements, reform of the disability determination process, permanent extension of continuing disability benefits pending appeal, and many other important program improvements. On the bulk of these issues, both the House and Senate have significant legislative histories in 1989. The challenge of 1990 is to mold these into a consensus that is approved by both bodies.

Significant differences between the House and Senate remain to be resolved. The Senate earnings test change was far more liberal than the House version. They also differ on the proposed leadership and organizational structure of an independent SSA; evidence compiled by the Special Committee on Aging suggest those differences should be resolved largely in favor of the Senate bill. The administration will fiercely resist any attempt to divorce SSA from DHHS, complicating its likelihood of passage. Members of Congress would help guard against a veto by opening lines of communication with the administration further than they reached in 1989.

A far more pervasive consensus was reached in 1989 on taking Social Security trust funds out of the Gramm-Rudman process, making its passage likely in 1990. The pressures raised by proposals to cut Social Security taxes increase the likelihood of taking Social Security out of Gramm-Rudman as a first step. Should the trust funds be further removed from the budget process, pressure to reduce administrative expenses may be eased sufficiently to begin rebuilding SSA as a premier Federal agency. Congress will be faced with deciding whether a pay-as-you-go system might have some merits over the current practice of using surpluses in the trust funds to finance the deficit. This question will not be entirely resolved by removing Social Security from Gramm-Rudman. The same financing practice will continue unless Congress achieves a balanced budget without counting Social Security reserves. At the same time, a Social Security tax cut without reform of Gramm-Rudman would require deep spending cuts or new taxes that would pose political problems for Congress.

Regarding the SSDI program, it appears clear that the 1984 reforms succeeded in halting the extensive and abusive administrative practices in the continuing disability review process in the early eighties. As a more complete and accurate picture comes into view, Congress can be expected to continue adjusting the law until its full intentions are realized to ensure the fair treatment of those entitled to benefits under the SSDI program. If Congress is shown a convincing record that SSA is not arbitrarily denying benefits to those who meet intended eligibility requirements, it would become more receptive to critics who inevitably point to abuses of the system. The challenge facing Congress and SSA is to strike a balance which fully addresses both of these concerns.

As the progress made in 1989 attests, the Social Security system retains the overwhelming support of the general public, the elderly, and many in the Congress. Given this support and adequate current financing, Social Security may be expected to continue on a stable path in the coming years.

Chapter 2

EMPLOYEE PENSIONS

OVERVIEW

Many employees receive retirement income from sources other than Social Security. Numerous pension plans are made available to employees from a variety of employers, including companies, unions, Federal, State, and local governments, the U.S. military, National Guard, and Reserve forces. The importance of the income these plans provide to retirees accounts for the notable level of congressional interest throughout recent years, which culminated in massive pension reforms during 1986.

Largely because of 1986 reforms, the Congress has enacted no new major revisions of the laws affecting pensions since that time. Indeed, most of the major retirement income policy issues that were debated in recent years had been either fully or partially resolved by legislation. However, there were some exceptions.

In 1987, Congress strengthened the requirements governing employer contributions to defined benefit plans, in order to assure adequate levels of assets for employee pension benefits. Concern also continued over how to treat the assets of overfunded pension plans. Some Members of Congress were concerned about the adequacy and safety of pension promises for employees participating in terminate pension plans. At this time, the debate on this issue continues both in Congress and in the pension community.

A. PRIVATE PENSIONS

1. Background

Employer-sponsored pension plans provide many retirees with a needed supplement to their Social Security income. Most of these plans are sponsored by a single employer and provide employees credit only for service performed for the sponsoring employer. However, 17 percent of all private plan participants are covered by multiemployer plans which provide members of a union with continued benefit accrual while working for any of a number of employers within the same industry and/or region. As of September 1987, 67.1 percent (52.7 million) of all wage and salary workers were covered by an employer-sponsored pension plan in 1984. Employees of larger firms were far more likely to be covered by an employer-sponsored pension plan than were employees of small firms. While business and repair service, retail trade, agricultural and personal service workers received a low rate of pension coverage, more than 70 percent of those employed by public utilities, professional and related services, and the manufacturing and mining industries were covered by a plan. According to 1985 data, private pension funds totaled $917 billion and accounted for 42 percent of the institutional assets in the economy. In 1986, Federal tax expenditures for public and private employer-sponsored pensions costs the Government $71 billion.

Most private plan participants are covered under a defined-benefit pension plan. The remainder participate in defined-contribution pension plans. Defined-benefit plans specify the benefits that will be paid in retirement, usually as a function of the worker's years of service under the plan or years of service and pay. The employer makes annual contributions to the pension trust based on estimates of the amount of investment needed to pay future benefits.

Defined-benefit plans generally base the benefit paid in retirement either on the employee's length of service or on a combination of his or her pay and length of service. Fewer than a third of all participants in medium and large size private plans receive benefits based on a fixed dollar amount for each year of service. Most fixed dollar plans cover union or hourly employees and are collectively bargained between the union and employer. The majority of pension plan participants are in salary-related plans that base the benefit on a fixed percentage of career average pay or final 3 or 5 years pay.

Workers in private-sector defined-benefit plans are typically in large primary pension plans funded entirely by the employer. More than three-quarters of the participants in defined-benefit plans are in plans with more than 1,000 participants. The largest employers generally supplement their defined-benefit plan with one or more defined-contribution plans. Where supplemental plans occur, the defined-benefit plan is usually funded entirely by the employer, and the supplemental defined-contribution plans are jointly funded by employer and employee contributions. Defined-benefit plans occasionally accept voluntary employee contributions or require employee contributions. However, fewer than 3 percent of the contributions to defined-benefit plans come from employees. Most of those contributing to their pension plans are government employees.

Defined-contribution plans, on the other hand, specify a rate at which annual or periodic contributions are made to an account. Benefits are not specified but are a function of the account balance, including interest, at the time of retirement.

Private pensions are provided voluntarily by employees. Nonetheless, the Congress has always required that pension trusts receiving favorable tax treatment benefit all participants without discriminating in favor of the highly paid. Pension trusts receive favorable tax treatment in three ways: (1) Employers deduct their current contributions even though they do not provide immediate compensation for employees; (2) income earned by the trust fund is tax-free; and (3) employer contributions and trust earnings are not taxable to the employee until received as a benefit. The major tax advantage, however, is the tax-free accumulation of trust interest (inside build-up) and the fact that the benefits are usually taxed at a lower rate than contributions.

In the last decade, the Congress has increasingly used special tax treatment as leverage to enforce widespread coverage and benefit receipt. In the Employee Retirement Income Security Act (ERISA) of 1974, Congress first established minimum standards for pension plans to ensure broad distribution of benefits and limited pension benefits for the highly paid. ERISA also established standards for funding and administering pension trusts, and added an employer-financed program of Federal guarantees for pension benefits promised by private employers.

In 1982, Congress sought in the Tax Equity and Fiscal Responsibility Act (TEFRA) to prevent discrimination in small corporations by requiring so-called "top heavy" plans—namely, plans in which the majority of plan assets benefit key employees—to accelerate vesting and provide a minimum benefit for short-service workers. Most of the general safeguards provided in TEFRA were later imposed on all plans in the Tax Reform Act, without repeal of the specific requirements on small businesses found in TEFRA.

In 1984, Congress enacted the Retirement Equity Act (REA) to improve the delivery of pension benefits to workers and their spouses. REA lowered minimum ages for participation to 21, provided survivor benefits to spouses of vested workers, and clarified the division of benefits in a divorce.

Title XI of the Tax Reform Act of 1986 made major changes in pension and deferred compensation plans in four general areas: (1) limits on an employer's ability to "integrate" or reduce pension benefits to account for Social Security contributions; (2) reform of coverage, vesting, and nondiscrimination rules; (3) changes in the rules governing distribution of benefits; and (4) modifications of limits on the maximum amount of benefits and contributions in tax-favored plans.

2. Issues and Legislative Responses

(A) BENEFIT ADEQUACY

The objective of retirement plans is to replace workers' preretirement earnings with sufficient benefits to maintain their standard of living during retirement. In 1981, the President's Commission on Pension Policy recommended that to achieve this goal, the average wage earner would need income from pensions, Social Security and other sources equal to approximately 75 percent of preretirement earnings. The Commission also recommended that "replacement ratios" for low-wage earners should be higher than for high-wage earners.

Because Social Security provides a higher replacement ratio to low earnings workers (25 percent), pensions often tilt their benefits the other way—providing a higher replacement to the higher paid. For example, a plan for a minimum wage worker receiving 54 percent of preretirement earnings from Social Security would only need to replace 20 to 35 percent of that person's preretirement earnings to meet a goal of 75 percent replacement. On the other hand, a worker paying the maximum Social Security tax (with 25 percent replacement from Social Security) would need to replace an additional 50 percent of preretirement earnings to meet that same ratio.

According to the Bureau of the Census, of all retirees receiving pension benefits in 1984, 66.4 percent were men. While the mean monthly pension income of male retirees was approximately $670, pension income for women was about $370 per month. The Census Bureau found that retirees under age 65 received higher pension income than those above age 65. Older retirees, however, were far more likely to be receiving Social Security benefits concurrently with their pensions.

Career patterns have the greatest effect on the amount of benefits paid by pension plans. Workers who enter plans late in life or work short periods under a plan earn substantially lower benefits than those who enter early and work a full career. The Department of Labor has found that the median benefit for workers with 10 years of service under their last pension plan replaced only 6 percent of their preretirement income while the median benefit of those with 35 years of service replaced 37 percent of preretirement income. Similarly, workers who entered the plan at a young age accumulate larger pensions than those who entered the plan late in life.

(1) Coverage

In 1984, 67 percent of all wage and salary workers were covered by an employer-sponsored pension plan. While the coverage rate for workers with monthly earnings below $500 was only 37.8 percent, those earning $2,000 or more each month were covered by a pension 84 percent of the time.

Employers who offer pension plans do not have to cover each of their employees. The law governing pensions—ERISA—permits employers to exclude part-time, newly hired, and very young workers from the pension plan. In addition, the law has required employers to cover, at most, only 70 percent of the remaining workers (only 56 percent if employees must contribute to participate in the plan); and an even smaller percentage of workers if the classification of workers the plan excludes does not result in the plan discriminating in favor of the highly paid.

The 1986 Tax Reform Act increased the minimum requirements for the proportion of an employer's work force that must be covered under company pension plans. Under prior law, a plan (or several comparable plans provided by the same employer) had to meet either a "percentage test" or a "classification test" to be qualified for deferral of Federal income taxes. Employers who were unwilling to meet the straight forward percentage test found substantial latitude under the classification test to exclude large percentages of lower paid workers from participating in the pension plan. Under the percentage test, the plan(s) had to benefit 70 percent of the workers meeting minimum age and service requirements (56 percent of the workers if the plan made participation contingent upon employee contributions). A plan could avoid having to meet this test if it could show that it benefited a classification of employees that did not discriminate in favor of highly compensated employees. Classifications actually approved by the Internal Revenue Service, however, permitted employers to structure plans benefiting almost exclusively highly compensated employees.

Pension coverage was expanded in the Tax Reform Act by raising the percentage of employees that must be covered under the percentage test, and by eliminating the classification test and replacing it with a much tougher and more specific alternative test: A "ratio test" and an "average benefit test." Under the new percentage test, 70 percent of non-highly-compensated workers must benefit (as opposed to 70 percent of all workers). Alternatively, an employer can benefit a smaller percentage of the company's work force if the number of non-highly-compensated workers benefiting is at least 70 percent of the number of highly compensated workers. The average benefit test permits employers to adjust the coverage requirements to take into account the level of benefits in the plan. Employers can meet this test by providing non-highly-compensated employees, on average, at least 70 percent of the average benefit of highly compensated employees (counting noncovered employees as having zero benefits). Plans are required to meet these new coverage requirements by January 1, 1989.

Most noncovered workers, however, work for employers who do not sponsor a pension plan. Nearly three-quarters of the noncovered employees work for small employers. Small firms tend not to provide pensions because a pension plan can be administratively complex and costly, often these firms have low profit margins and uncertain futures, and the tax benefits of a pension plan for the company are not as great for small firms.

Projected trends in future pension coverage have been hotly debated. The expansion of pension coverage has been slowing steadily over the last few decades. The most rapid growth in coverage occurred in the 1940's and 1950's when the largest employers adopted pension plans. It is unlikely that pension coverage will grow much without some added incentive for small business to add pension plans and for employers to include currently excluded workers in their plans.

(2) Vesting

Simply because a worker may be covered by a pension plan does not insure that he or she will receive retirement benefits. To receive retirement benefits, a worker must vest under the company plan. Vesting entails remaining with a firm for a requisite number of years and therefore earning the right to receive a pension.

Vesting provisions are a simple way to insure that benefits do not go to short-term workers, as well as to induce certain workers to remain on the job. Indeed, those employees who are only a few years short of vesting tend to remain on the job until they are assured of receiving a retirement benefit.

Most workers today do not stay with the same employer the number of years required to vest in their pension plans. ERISA standards have required that plans which vest no benefits during the first 10 years of employment fully vest those benefits after 10 years of employees service. Due to declining job tenure, today's workers are having more difficulty earning pensions than did their predecessors. The average job tenure for a male aged 40–44, for example, has dropped from 9.5 years in 1966 to 8 years in 1981. Women's average job tenures are declining less rapidly—but already tend to be much shorter than those of men. Job tenure for women aged 40–44 dropped from 4.1 years in 1966 to 3.9 years in 1981.

To enable more employees to either partially or fully vest in a pension plan, the 1986 Tax Reform Act required more repaid vesting than in the past. The new provisions, which apply to all employees working as of January 1, 1989, will require that if no part of a benefit is vested prior to 5 years of employee service, then benefits must be fully vested at the end of 5 years. If a plan provides for vesting of 20 percent of the benefit after 3 years, then full vesting is required at the end of 7 years of service.

(3) Benefit Distribution and Deferrals

Vested workers who leave an employer before retirement usually have the right to receive vested deferred benefits from the plan when they reach retirement age. Benefits that can only be paid this way are not portable in that the departing worker may not transfer the benefits to his or her next plan or to a savings account. Many pension plans, however, allow a departing worker to take a lump-sum cash distribution of his or her accrued benefits.

Federal policy regarding lump-sum distributions has been inconsistent. On the one hand, Congress formerly encouraged the consumption of lump-sum distributions by permitting employers to make mandatory distributions without the consent of the employee on amounts of $3,500 or less; and by providing favorable tax treatment through the use of the unique "10-year forward averaging" rule (permitting the tax payment to be calculated as though the individual had no other income). On the other hand, Congress has tried to encourage departing workers to save their distributions by deferring taxes if the amount is rolled into an individual retirement account (IRA) within 60 days.

IRA rollovers, however, appear to have been largely ineffective. To the extent that workers receive lump-sum distributions, they tend to spend them rather than save them; thus distributions appear to reduce retirement income rather than increase it. Recent data indicate that only 5 percent of lump-sum distributions are saved in a retirement account and only 32 percent are retained in any form. Even among older and better educated workers, fewer than half roll their preretirement distributions into a retirement savings account.

How and when a plan distributes benefits to employees is a key factor in that plan's ability to deliver adequate retirement benefits. Even if a worker is vested, he or she may lose pension benefits under some plans upon changing jobs. This benefit loss results from differences in how some plans accrue benefits.

Final-pay formulas have been popular with employees because they relate the pension benefit to the worker's earnings immediately preceding retirement. However, final-pay plans penalize workers who leave the plan before retirement by freezing benefits at the last pay level under the plan. Workers who are years from retirement will often be entitled to pension benefits of little value. Therefore, a mobile worker earning benefits under several final-pay plans will receive much lower benefits than a steady worker who spends a full career under a single plan.

Traditionally, different types of plans have distributed their benefits in different forms. Defined-benefit pension plans have generally provided distributions only in the form of an annuity at retirement, while defined-contribution pension, profit-sharing, or thrift plans have generally provided distributions as a lump-sum payment whenever an employee leaves the company.

The Tax Reform Act of 1986 established substantial disincentives to use pension or deferred compensation plan accruals for any purpose other than providing a stream of retirement income. It imposes an excise tax of 10 percent on distributions from a qualified plan before age 59½, other than those: Taken as a life annuity, taken upon the death of the employee, taken upon early retirement at or after age 55, or used to pay medical expenses.

(4) Pension Integration

Current rules permitting employers to reduce pension benefits to account for Social Security benefits can result in an excessive reduction of lower paid workers' pension benefits. Under the Social Security program, employees generally pay a uniform tax rate but receive Social Security benefits that are proportionately higher at lower levels of income. Employers who want to blend their pension benefits with Social Security benefits to achieve a more uniform rate of income replacement for their retirees use integration to accomplish this goal. The integration rules define the amount of adjustment a plan can make to pension benefits before the plan is considered discriminatory.

In general, two types of integration exist—excess and offset. In excess integration, plans pay a higher contribution or benefit on earnings above a particular level (the "integration level") than they pay on earnings below that level; current rules permit plans to make no contributions below the integration level. In offset integration, plans reduce the pension benefit by a percentage of the Social Security benefit, which can result in the elimination of an individual's entire pension.

In the past, pension integration could be used unfairly, thus depriving workers of legitimate benefits. Internal Revenue Service rulings permitted a defined-contribution plan to provide contributions on pay above the Social Security wage base ($45,000 in 1988) at a rate 5.7 percent higher than those provided on pay below the wage base. Plans could provide no contributions on pay below the wage base if the contribution rate above the wage base was 5.7 percent or less. The rulings permitted a defined-benefit plan to meet either an excess plan or an offset plan rule. In the excess plan, the difference in benefits as a percentage of final earnings paid above and below the average Social Security wage base could not exceed 37.5 percent. In the offset plan, the final pension benefit could be reduced by an amount equal to 83.3 percent of the Social Security benefit. In practice, pension benefits were often eliminated for workers with low wages.

Tax Reform modified the amount of integration permissable under the revenue rulings to prevent the elimination of pension benefits. Under the new integration rules, participants receive a minimum of 50 percent of the pension benefit they would receive without integration. Defined-contribution plans cannot contribute above the wage base at a rate more than twice the rate they contribute below the wage base and in no case can they have a differential greater than that under prior law (5.7 percent). Excess plans cannot pay benefits on final pay above the wage base at a rate exceeding twice the rate they pay below the wage base, nor can they have a differential in the rate exceeding three-fourths of a percent times years of service. Offset plans cannot pay less than 50 percent of the pension benefit that would have been paid without integration and in no case can they reduce the pension by more than three-fourths of a percent of the participant's final average pay multiplied by years of service. The new integration rules apply to contributions or benefits that became effective January 1, 1989.

(B) TAX EQUITY

Private pensions are encouraged through tax benefits, estimated by the Treasury to be $40 billion in 1990. In return, Congress regulates private plans to prevent over-accumulation of benefits by the highly paid. Congressional efforts to prevent discriminatory provisions of benefits have focused on the potential for discrimination in voluntary savings plans and on the effectiveness of current coverage and discrimination rules.

In recent years, there has been a substantial increase in tax-free individual contributions to retirement and savings plans. Prior to 1974, only employees of public or tax-exempt organizations could elect to defer a portion of their salary without paying income taxes on it through a tax-sheltered annuity (TSA) as established under section 403(b) of the Internal Revenue Code. Private sector employees could make only after-tax contributions to a retirement plan. Beginning in 1974, the Congress gradually extended the opportunity to make tax-free elective deferrals to all employees. In 1974, Congress enacted legislation permitting workers not covered by a employer-sponsored pension plan to defer up to $2,000 a year to an individual retirement account (IRA). Then, in 1978, they authorized cash or deferred arrangements (CODA's) for private employees under section 401(k). Workers covered under a CODA may make elective tax-free contributions (by agreeing with the employer to reduce their salaries) to an employer plan. The rules limited the amount that any worker could contribute by the total limit on all pension contributions (25 percent of salary up to $30,000) and by separate nondiscrimination test for 401(k) plans restricting the average percentage of salary deferred by highly paid workers to 150 percent of the average percentage of salary deferred by lower paid workers. Finally, in 1981 Congress opened up the opportunity to defer $2,000 a year in an IRA to all workers.

Before 1986, concern had grown that tax-free voluntary savings offered too great a tax shelter for the highly paid and was inequitable. The tax benefits of voluntary savings are most attractive to those in the highest tax brackets. Concern grew that while a large portion of the tax benefits went to those who would probably save for retirement without it, many who needed the retirement savings did not benefit from the tax provisions. In addition, there was some concern that the aggregate tax expenditures to encourage savings had become excessive. For example, the majority of those using IRA's in the past were also participating in a corporate pension or 401(k) plan.

Nondiscrimination rules are intended to ensure that employee benefit plans that are tax-favored are of benefit to a broad cross-section of employees and not just the highly paid. Corporate pension and deferred compensation plans are required to meet a number of nondiscrimination tests for coverage and comparability of benefits as set forth in sections 401 and 410 of the Internal Revenue Code (and various revenue rulings) to become tax-qualified. Plans are required to benefit either 70 percent of the employees who meet age and service requirements (56 percent in a contributory plan) or a classification of employees that the Secretary of the Treasury finds not to be discriminatory. Benefits provided in one or a number of plans by the same employer must be reasonably comparable (in relation to pay) at various pay levels.

CODA's, in which participation is optional for the employees, must meet an additional nondiscrimination test based on the use of the plan, to ensure that the highly paid are not benefitting disproportionately from the plan.

Before 1986, there was growing concern that the coverage rules were too loosely structured and had been weakened too much through revenue rulings to ensure broad participation in employer plans by lower paid workers. In addition, there had been some concern that the CODA discrimination rules permit excessive deferrals by the highly paid in relation to the amounts actually deferred by the lower paid. Tax-sheltered annuities have not been exempt from nondiscrimination requirements for tax qualified plans since these were established under a separate section 403(b).

(1) Limitations on Tax-Favored Voluntary Savings

The Tax Reform Act tightens the limits on voluntary tax-favored savings plans in an effort to target limited tax resources where they can be most effective in producing retirement benefits. The Act repeals the deductibility of contributions to an IRA for participants in pension plans with adjusted gross incomes (AGI's) in excess of $35,000 (individual) or $50,000 (joint)—with a phased-out reduction in the amount deductible for those with AGI's within $10,000 below these levels. It also reduces the dollar limit on the amount employees can elect to contribute through salary reduction to an employer plan from $30,000 to $7,000 per year for private sector 401(k) plans and to $9,500 per year for public sector and nonprofit 403(b) plans. Additionally, the Act tightens the nondiscrimination test that further limits the elective contributions of highly compensated employees in relation to the actual contributions of lower paid employees. Finally, the Act encourages the small employer adoption of pension plans by permitting employers with fewer than 25 employees to adopt simplified employer pensions (SEP's) with elective employee deferrals.

(2) Limitations on Benefits and Contributions

The Internal Revenue Code limits the amount of additional accumulation an individual can have each year in a tax-favored plan.

Under prior law, the annual benefit payable from a defined-benefit plan could not exceed 100 percent of an individual's compensation (up to a maximum benefit of $90,000). The annual contribution made to a defined-contribution plan could not exceed 25 percent of compensation (up to a maximum of $30,000). If an employee participates in both defined-benefit and defined-contribution plans, their total accumulation is subject to a combined limit. The dollar limits are indexed to allow cost of living increases.

In recent years, the Congress has reduced and frozen the Section 415 limits largely in an effort to raise revenue for the Federal Government in the context of deficit reduction. The Tax Reform Act restores the indexing of the Section 415 limits, modifies the relationship between the benefit and contribution amounts to establish parity, and changes the adjustment in the defined-benefit dollar limit for early retirement. The defined-benefit limit would be indexed for inflation beginning in 1987, while the defined-contribution limit would remain frozen until the defined-benefit limit is four times as great—a ratio of contributions to benefits that is believed to result in roughly equal retirement benefits. Once the four-to-one ratio is reached, both limits would be indexed. Although, the defined-benefit limit remains the same for benefits commencing at age 65, the Tax Reform Act requires full actuarial reduction for benefits paid at earlier ages—so that the maximum annual benefit for someone retiring at age 55 is reduced from the current floor of $75,000 to $40,000.

To reduce the potential for an individual to overaccumulate by using several plans, the Tax Reform Act both retains the current law combined limit and adds a 15 percent excise tax to recapture the tax benefits of annual benefits (including IRA withdrawals) in excess of 125 percent of the defined-benefit limit (but not less than $150,000).

One of the major purposes of the retirement provisions of the Tax Reform Act of 1986 is to expand the proportion of the population receiving pension benefits and raise average benefits from employer-sponsored plans. Data prepared by ICF, Inc. for the American Association of Retired Persons (AARP) indicates that the combination of expanded coverage, 5-year vesting, limits on pension integration, and tighter distribution rules is expected to substantially increase future benefits paid to today's younger workers. The study simulated the pension income received by the families of workers who will reach age 67 in the years 2011-2020. The benefit improvements in the Tax Reform Act will raise average annual family pension income from $8,400 (under prior law) to $10,200 (1986 dollars) and will increase the percentage of families receiving pension income from 68 percent (under prior law) to 77 percent. Women, in particular, are expected to benefit from the pension reforms. ICF estimated that the Tax Reform Act changes will increase the number of women with pension benefits during the 2011-2020 period by 23 percent.

(C) PENSION FUNDING

The contributions plan sponsors set aside in pension trusts are invested to build sufficient assets to pay benefits to workers throughout their retirement. The Federal Government, through the Employee Retirement Income Security Act of 1974 (ERISA), regulates the level of funding and the management and investment of pension trusts. Under ERISA, plans that promise a specified level of benefits (defined-benefit plans) must either have assets adequate to meet benefit obligations earned to date under the plan or must make additional annual contributions to reach full funding in the future. Plans created since 1974 must reach full funding within 30 years. Plans predating ERISA are allowed 40 years to develop full funding. Under ERISA, all pension plans are required to diversify their assets, are prohibited from buying, selling, exchanging, or leasing property with a "party-in-interest," and prohibited from using the assets or income of the trust for any purpose other than the payment of benefits or reasonable administrative costs.

Prior to ERISA, participants in underfunded pension plans lost their benefits when employers went out of business. To correct this problem, ERISA established a program of termination insurance to guarantee the vested benefits of participants in single-employer defined-benefit plans. This program guaranteed benefits up to $1,858 a month in 1987 (adjusted annually). As of 1986, the single-employer program was funded through annual premiums of $8.50 per participant paid by employers to a nonprofit Government corporation—the Pension Benefit Guaranty Corporation (PBGC). When an employer terminated a plan, the PBGC received any assets in the plan and made a claim against additional assets up to 30 percent of the employer's net worth. A similar termination insurance program was enacted in 1980 for multiemployer defined-benefit plans, using a slightly higher annual premium, but guaranteeing only a portion of the participant's benefits.

During 1988, continued attention was focused on three important pension funding issues: (1) Termination of underfunded plans; (2) reversions of assets from termination of overfunded plans; and (3) investment performance of pension funds.

(1) Termination of Underfunded Plans

The past 5 years have brought increasing concern that the single-employer termination insurance program, operated by the PBGC, is inadequately funded. By the end of fiscal year 1984, PBGC had liabilities of $1.5 billion and assets of only $1.1 billion—leaving a deficit of $462 million. Projections at that time indicated that without a premium increase the fund for single-employer plans would be exhausted by 1990. During 1985 the PBGC assumed $615 million in additional liabilities. By the end of fiscal year 1985, the PBGC reported liabilities of $2.7 billion and assets of only $1.4 billion, leaving a deficit of $1.3 billion.

A major cause of the PBGC's problem was the ease with which economically viable companies could terminate underfunded plans and dump their pension liabilities on the termination insurance program. Employers unable to make required contributions to the pension plan were requesting funding waivers from the IRS, permitting them to withhold their contributions, and thus increase their unfunded liabilities. As the underfunding grew, the company terminated the plan and transferred the liability to the PBGC. The

PBGC was helpless to prevent the termination and was also limited in the amount of assets that it could collect from the company to help pay for underfunding to 30 percent of the company's net worth. PBGC was unable to collect much from the financially troubled companies since they were likely to have little or no net worth.

Terminations of underfunded pension plans have also reduced the benefits paid to participants and beneficiaries. Even though vested benefits are generally insured by the PBGC, the termination insurance program does not protect all benefits vested in underfunded plans. Employees are often in a difficult position when an employer terminates an underfunded plan. On the one hand, termination will result in a loss of benefits. On the other hand, the inability of the company to restructure its debt may force the company to go out of business and the workers to lose their jobs.

While during the past few years, the PBGC has assumed responsibility for several large claims, none was as large as that of the LTV Corporation, which filed for Chapter 11 bankruptcy in 1986. LTV's three terminated steel pension plans doubled PBGC's deficit from $2 billion to $4 billion and illustrated a fundamental weakness of the termination insurance program. Under the law, companies such as LTV could eventually become profitable, in part because they had succeeded in dumping pension liabilities on the PBGC. The result was that participants in the pension plans of such companies (through some loss in benefits) and the companies' competitors (through higher premiums to the PBGC) were subsidizing their future profitability.

During 1986, several important events took place with regard to pension underfunding. First, the premium paid to the PBGC by employers was increased from $2.60 to $8.50 per participant. In addition the circumstances under which employers can terminate underfunded pension plans and dump them into the PBGC's lap were tightened up considerably. A distinction is now made between "standard" terminations, where the employer is not in financial trouble and "distress" terminations, where the employer is unlikely to have adequate assets to meet plan obligations. In a standard termination, employers will have to pay all benefits commitments under the plan, including benefits in excess of the amounts guaranteed by the PBGC that were vested prior to termination of the plan. A distress termination—where a company has filed for bankruptcy, or will clearly go out of business unless the plan was terminated, or where the cost of the pension has become unreasonably burdensome—involves increased employer liability to both the PBGC and plan participants.

While significant accomplishments were made in 1986, however, the new changes did not solve the PBGC's financing problems. The insurance agency's troubles grew substantially worse with the termination of the pension plans of the bankrupt LTV Corporation at the end of 1986 and beginning of 1987. As a remedy, a provision in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) calls for an additional PBGC premium increase as of 1989. Beginning in 1989, firms will be required to pay a premium ranging from $16 to $50 per employee. This "variable-rate premium" will penalize those companies with large unfunded liabilities. While the companies sponsoring the 83 percent of all pension plans which are adequately funded will only be required to pay $16 per employee, companies sponsoring the remaining 17 percent will be forced to pay a variable premium, according to their level of underfunding. The new law will require companies to pay an additional $6 per employee for each $1,000 of underfunding. According to the PBGC, roughly 4 percent of all plans will pay the maximum rate of $50 per employee. Companies will also be required to make quarterly payments to the PBGC, rather than annual payments as has been the case. Due to the difficult conditions presently existing in the steel industry, the new provisions gave steel companies a 5-year transition period.

The new variable-rate premium resulted from lengthy debate. The Administration had proposed a variable-rate premium ranging from $8.50 to $100 per employee. Unions bitterly opposed the Administration proposal, stating that it would deepen the crises of companies which are already financially troubled. Therefore, the unions favored a Democratic alternative calling for a $20 flat-rate premium. However, this idea was unacceptable to the business community. In the end, the above-mentioned compromise was enacted into law.

The premium increase aside, however, PBGC's financial picture could be helped drastically if the agency is successful in returning to LTV the responsibility for administering its three pension plans. While the PBGC took the plans over in January 1987, in September, after LTV had reported substantial operating profits, the PBGC won a court decision to return the plans to the company. LTV subsequently filed suit to return the plans to the PBGC. While LTV maintains that its business situation has not improved enough to warrant the return of the plans, others argue that if LTV is allowed to reduce its liabilities through bankruptcy, other firms will feel free to do so. The LTV case is still pending, but a decision is expected sometime in 1989. Should the PBGC be successful, however, its $4 billion deficit would be cut in half.

(2) Reversions of Assets From Termination of Overfunded Plans

Concern in the Congress continues over the termination of overfunded defined-benefit pension plans to enable plan sponsors to recapture the surplus assets. Under ERISA, sponsors of plans with assets that exceed ERISA funding standards can recover these surplus assets over time by reducing their contributions to the plan. Withdrawals of assets are not permitted as long as the plan remains in operation. Employers can recover assets, however, when a plan is terminated.

In recent years, a substantial increase in plan surpluses due to bond and stock market gains and an increasing awareness of the potential for recovering plan assets, has caused employers to consider terminating well-funded defined-benefit plans for a variety of business reasons unrelated to the purposes of the retirement plan. The major reasons for termination have included: Financing or fending off corporate takeovers, improving cash flow or redirecting the company's assets, and modifying the company's retirement income plans.

Originally, employers were loathe to terminate pension plans simply to recover assets because of a concern that the PBGC would prevent them from offering a similar successor plan. The issuance of Implementation Guidelines for Asset Reversions by the PBGC, Treasury Department, and Department of Labor in May 1984 helped clarify that an employer could terminate one plan and establish a similar successor plan as long as all plan participants were vested and benefits were fully covered under annuity contracts. This clarification has given rise to a host of new plan terminations that have left participants covered under identical or similar, and sometimes less secure successor plans.

The number and size of reversions from plan terminations has been increasing steadily in recent years. Since 1980, employers have terminated more than 1,300 pension plans and recovered nearly $16 billion in assets. The largest reversion in history occurred in 1985 when United Airlines recovered over $962 million through the termination of five pension plans.

Employees whose company terminates a pension plan to recover its assets usually remain covered under the old plan or a successor plan. The two common methods for leaving participants covered under a defined-benefit plan—"spinoff" termination and "re-establishment" termination—essentially leave participants benefits unchanged. Under a spinoff, the old pension plan is split in two—one-half covering retirees and the other half active employees. While active employees remain in the old plan, the surplus assets are placed in the retiree plan, which is terminated, and annuities are purchased for the retirees. Under a re-establishment, the old pension plan is terminated and a new similar plan is created, with past service credits normally provided in the new plan for all active employees.

Many have raised serious concerns about the equitability of employer recovery of excess pension plan assets. Critics argue that retirees can be harmed in a spinoff termination because they might lose the potential for future cost-of-living increases in their benefits. They also contend that reversions draw needed assets from the plans and may increase the risk for the PBGC because newly created plans are not required under ERISA to maintain a funding level as high as plans that have been in existence for some time.

Plan sponsors counter that the real problem is that to recover excess assets, employers are currently forced to terminate pension plans. They believe that since the company, in a defined-benefit plan, promises specified benefits to employees, only the benefits earned to date—not the assets in the plan—belong to participants. The sponsors argue that employers are responsible for adequately funding these benefits and should be permitted to recover funds not needed to pay benefits. Under current law, employers can reduce their contributions to recover surpluses over time. Employers argue they should not have to wait.

Some observers have suggested that the recovery of these additional assets is weakening the funding of pension plans and undermining the purposes of the ERISA funding standards. They have proposed that sponsors should be permitted to recover the assets not needed on a continuing basis but be prevented from recovering additional assets if they are going to continue coverage for their employees under a successor plan.

In the 100th Congress, the reversion debate centered around whether or not employees should share the benefits of asset recovery. Proposals of the Senate Finance Committee and the House Ways and Means Committee essentially retained current law by disallowing asset withdrawals from ongoing pension plans. The House version, however, called for an asset cushion in the event of a termination withdrawal and a 20 percent excise tax on plan reversions. A 10 percent excise tax was passed as part of the Tax Reform Act of 1986.

Critics of the tax committee proposals argued that preventing firms from withdrawing excess assets acts as an incentive for plan terminations, thus jeopardizing retiree benefit security. They added that such prohibitions could encourage plan underfunding. Proponents, on the other hand, claimed that excess assets should be used to fund plan improvements such as cost-of-living adjustments. While they believed that these strict rules are the only way to effectively guarantee benefit security, critics contend that benefit security necessitates discouraging plan terminations.

The submissions of the House and Senate Labor Committees would have allowed asset withdrawals, but would have required that employers share the excess assets with their employees. Withdrawals, of excess funds would be permitted if a cushion of 125 percent of liabilities was left in each plan maintained by the company. Were a plan to be terminated, employers would be required to share a portion of its assets with their employees.

Some commentators proposed that employers only be allowed to withdraw excess assets if they also restored the value of retirees' pensions. Such an undertaking would entail increasing the monthly benefits for retirees by 100 percent of the increase in the Consumer Price Index since the date of their retirement. Unlike Federal retirement programs, private pension plans are not required to provide for increases in the cost-of-living. Advocates argued that only when both pension benefits and their value are protected can employers justifiably recover excess assets.

Despite the intense debate over this issue, no resolution has been reached. Companies may still terminate plans and recover excess assets. Without a doubt the intensity of this debate will ensure future consideration on the part of Congress.

(D) PENSION ACCRUAL

A provision in the Omnibus Budget Reconciliation Act of 1986 required that the IRS, the Equal Employment Opportunity Commission (EEOC), and the Department of Labor issue regulations requiring employers to continue accruing pension benefits for employees working beyond normal retirement age by early 1988. Under Public Law 99-509, the IRS, followed by the EEOC and the Department of Labor, were required to develop regulations in accordance with the new law.

In April 1988, the IRS proposed a rule providing that in defined-benefit plans all years of service be taken into account in determining retirement benefits. In contrast, with respect to defined-contribution plans the law would not be applied retroactively under the IRS ruling. Under the rule, a worker with a defined-benefit plan and who turns 65 prior to 1988 would accrue pension credits for years of service prior to the law's 1988 effective date. However, if the same worker were covered by a defined-contribution plan, only employment after January 1988 would be credited. According to the IRS, until a final rule is issued, the proposed regulations are in effect. On December 9, 1988, the EEOC announced that it would issue a regulation conforming to the IRS rule. (See Chapter 4, pension accrual section.)

(E) PENSION COVERAGE BY SMALL EMPLOYERS

During the 100th Congress, a bill introduced by Senator David Pryor to encourage small businesses to provide their employees with pension coverage received attention. Entitled "The Small Business and Retirement Extension Act" (S. 1426), the bill would have provided a new tax credit for administrative costs incurred in connection with maintaining a pension plan, as well as repealing top-heavy rules.

While a number of small business representatives supported repealing the top-heavy rules, some commentators complained that bill supporters could not substantiate that the rules now place an excessively heavy burden on small businesses. Proponents of the bill maintained that the pension reforms in the Tax Reform Act of 1986 regarding integration and vesting make the top-heavy rules unnecessary.

Due to a number of unresolved issues, no final action was taken on the legislation by the close of the 100th Congress. Senator Pryor, however, is expected to renew his efforts in the future to promote increased pension coverage of workers in the Nation's small businesses.

3. Prognosis

Many of the pension issues that have commanded attention in recent years were resolved in 1986. Pension funding issues, however, remain a major concern. While the financial picture of the Pension Benefit Guaranty Corporation should be aided by the premium increase scheduled for 1989, other issues such as reversions of excess pension assets promise to receive a great deal of attention in the near future. Among the cogent issues which must be addressed is whether employees are entitled to receive a portion of recovered assets. In addition, the question of whether or not an employer should be allowed to withdraw excess assets without terminating a pension plan is extremely important.

The issue of pension portability also promises to receive some attention. Pension benefit portability involves the ability to maintain an employee's benefits upon a change in employment. Proponents argue that the mobility of today's work force demands benefit portability. Alternatives to expand pension portability that will likely receive attention during 1989 include proposals to establish a Federal portability agency or a central clearinghouse, which would maintain accounts on behalf of workers, and proposals to expand the current retirement arrangements to require or facilitate rollovers of preretirement distributions to an employer plan or an IRA.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

1. BACKGROUND

State and local government pension plans cover 11.4 million active and 3.1 million retired participants in more than 6,600 plans. As of December 31, 1987, State and local pension plans had assets of $513.5 billion. More than 80 percent of these plans have fewer than 100 active members each. About 95 percent of active memberships are included in the largest 6 percent of plans. Nearly three-quarters of the State and local plans provide coverage under Social Security, but most do not integrate Social Security and pension benefits.

State and local pension plans intentionally were left outside the scope of Federal regulation under ERISA in 1974, even though there was concern at the time about large unfunded liabilities and the need for greater protection for participants. Although unions representing State and municipal employees, from the beginning, have supported the application of ERISA-like standards to these plans, opposition from local officials and interest groups thus far have successfully counteracted these efforts, arguing that the extension of such standards would be an unwarranted and unconstitutional interference with the right of State and local governments to set the terms and conditions of employment for their workers.

(A) TAX REFORM ACT OF 1986

Public employee retirement plans were affected directly by several provisions of the Tax Reform Act of 1986. The Act made two changes that apply specifically to public plans: (1) The maximum employee elective contributions to voluntary savings plans (401(k), 403(b), and 457 plans) were substantially reduced, and (2) the once-favorable tax treatment of distributions from contributory pension plans was eliminated.

(B) ELECTIVE DEFERRALS

The Tax Reform Act set lower limits for employee elective deferrals to savings vehicles, coordinated the limits for contributions to multiple plans, and prevented State and local governments from establishing new 401(k) plans. The maximum contribution permitted to an existing 401(k) plan was reduced from $30,000 to $7,000 a year and the nondiscrimination rule that limits the average contribution of highly compensated employees to a ratio of the average contribution of employees who do not earn as much was tightened. The maximum contribution to a 403(b) plan (tax-sheltered annuity for public school employees) was reduced to $9,500 a year and employer contributions for the first time were made subject to nondiscrimination rules. In addition, preretirement withdrawals were restricted unless due to hardship. The maximum contribution to a 457 plan (unfunded deferred compensation plan for a State or local government) remained at $7,500, but is coordinated with contributions to a 401(k) or 403(b) plan. In addition, 457 plans were required

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to commence distributions under uniform rules that apply to all pension plans. The lower limits were effective for deferrals made on or after January 1, 1987, while the other changes generally will be effective beginning January 1, 1989.

(C) TAXATION OF DISTRIBUTIONS

The tax treatment of distributions from public employee pensions plans also was modified by the Tax Reform Act to develop consistent treatment for employees in contributory and noncontributory pension plans. Under prior law, public employees who had made after-tax contributions to their pension plans could receive their own contributions first (tax-free) after the annuity starting date if the entire contribution could be recovered within 3 years, and then pay taxes on the full amount of the annuity. Alternately, employees could receive annuities in which the portions of nontaxable contributions and taxable pensions were fixed over time. The Tax Reform Act repealed the 3-year basis recovery rule that permitted tax-free portions of the retirement annuity to be paid first. Under the new law, retirees from public plans must receive annuities that are a combination of taxable and nontaxable amounts.

The tax treatment of preretirement distributions was changed for all retirement plans in an effort to discourage the use of retirement money for purposes other than retirement. A 10-percent penalty tax applies under the new law to any distribution before age 59½ other than distributions in the form of a life annuity: At early retirement at or after age 55; in the event of the death of the employee; or in the event of medical hardship. In addition, refunds of after-tax employee contributions, and payments from 457 plans are not subject to the 10-percent penalty tax. The new tax law also repealed the use of the advantageous 10-year forward-averaging tax treatment for lump-sum distributions received prior to age 59½, and provides for a one-time use of 5-year forward averaging after age 59½.

The Act also made a number of changes that apply to tax-qualified pension plans, but do not apply directly to government plans. These include a reduction in the vesting period from 10 years to 5 years, modifications in the rules for integration of pension and Social Security benefits to require payment of at least half of a nonintegrated pension benefit, tighter pension coverage, and nondiscrimination rules to encourage broader participation in pension plans by lower paid employees.

2. ISSUES

(A) FEDERAL REGULATION

Issues surrounding Federal regulation of public pension plans have changed little in the past 10 years. A 1978 report to Congress by the Pension Task Force on Public Employee Retirement Systems concluded that State and local plans often were deficient in funding, disclosure, and benefit adequacy. The Task Force reported many deficiencies that still exist, including:

Government retirement plans, particularly smaller plans, frequently were operated without regard for generally accepted financial and accounting procedures applicable to private plans and other financial enterprises.

There was a general lack of consistent standards of conduct.

Open opportunities existed for conflict-of-interest transactions, and frequent poor plan investment performance.

Many plans were not funded on the basis of sound actuarial principles and assumptions, resulting in inadequate funding that could place future beneficiaries at risk of losing benefits altogether.

There was a lack of standardized and effective disclosure, creating a significant potential for abuse due to the lack of independent and external reviews of plan operations.

Although most plans effectively met ERISA minimum participation and benefit accrual standards, two of every three plans, covering 20 percent of plan participants, did not meet ERISA's minimum vesting standard.

There remains considerable variation and uncertainty in the interpretation and application of provisions pertaining to State and local retirement plans, including the antidiscrimination and tax qualification requirements of the Internal Revenue Code. While most administrators seem to follow the broad outlines of ERISA benefit standards, they are not required to do so. Recent studies suggest that the growth rate of public funds is outstripping the growth of private plans as public fund administrators move aggressively to fund unfunded liabilities. The sheer size of the investment funds suggests that a Federal standard might be prudent.

However, the need for improved standards has not obscured the latent constitutional question posed by Federal regulation. In *National League of Cities versus Usery,*[1] the U.S. Supreme Court held that extension of Federal wage and maximum hour standards to State and local employees was an unconstitutional interference with State sovereignty reserved under the 10th Amendment. State and local governments have argued that any extension of ERISA standards would be subject to court challenge on similar grounds. The Supreme Court's decision in 1985 in *Garcia* v. *San Antonio Metropolitan Transit Authority*[2] overruling *National League of Cities* largely has resolved this issue in favor of Federal regulation.

Perhaps in part because of the lingering question of constitutionality, the focus of Congress has been fixed on regulation of public pension with respect to financial disclosure only. Some experts have testified that much of what is wrong with State and local pension plans could be cleared by greater disclosure.

A definitive statement on financial disclosure standards for public plans was issued in 1986 by the Government Accounting Standards Board (GASB). Statement No. 5 on "Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Governmental Employers" established standards for disclosure of pension information by public employers and public employee retirement systems (PERS) in notes in financial statements and in required supplementary information. The disclosures are intended to provide information needed to assess the funding status of PERS, the progress made in accumulating sufficient assets to pay benefits, and the extent to which the employer is making actuarially determined contributions. In addition, the statement requires the computation and disclosure of a standardized measure of the pension benefit obligation. The statement further suggests that 10-year trends on assets, unfunded obligations, and revenues be presented as supplementary information.

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[1] 426 U.S. 883 (1979).

[2] 83 L.Ed.2d 1016, 53 U.S.L.W. 4135 (1985).

(B) INVESTMENT PERFORMANCE

The most important occurrence to affect State and local pension funding during 1987 was the October 19 stock market crash, known as Black Monday. On Black Monday, the Nation's pension plans lost $210 billion in fund assets, much of this involving State and local plans. It is important to note, however, that while these plans lost a large portion of their assets as a result of the crash, they also had benefitted appreciably from the preceding bull market. As of December 2, 1987, State and local government plan assets totaled approximately $479 billion. While this was appreciably lower than the $562 billion in assets these plans had accumulated as of August 25, 1987, it was closer to the $503 billion in assets they owned on December 31, 1986. In fact, assets after Black Monday were higher than at the end of 1985, when State and local pension plan assets totaled about $432 billion.

State pension funds were seriously weakened by Black Monday. The Wisconsin State Employees Pension Fund for example, suffered a 20-percent loss in market value for the week of October 19, 1987, seeing its assets drop by well over $1 billion. The Michigan retirement fund also lost approximately $1 billion. While these losses were significant, they must be put in the proper perspective. For example, prior to the crash, the Michigan fund had assets of $16 billion. While one-sixteenth of those assets was lost on Black Monday, the Michigan State Treasurer's office has said that because of the previous bull market, Michigan's pension fund remains nearly $10 billion richer than it was in 1983. The story was similar in Wisconsin. According to the State of Wisconsin's Investment Board, Wisconsin's stock values on November 9, 1987 were about the same as they had been on January 1, 1987.

Like private plans, State and local plans were insulated partially from the market collapse by diversification in bonds, cash, and other nonequity investments. State and local plans were hardest hit by a decrease in the value of their equity holdings. The total value of State and local plans' equity holdings as of December 2, 1987 was $177 billion. This compares with pre-crash holdings of $255 billion on August 25, 1987 and $180 billion on December 31, 1986. The decline put State and local plan equity holdings in December 1987 within 2 percent of their value at the end of 1986.

The value of bonds held by State and local plans also experienced a slight decline. While their value had been $282 billion at the end of 1986, they had declined to $266 billion, by August 25, 1987, with a further decline to $261 billion by December 2, 1987.

On the whole, State and local pension plan investments recovered losses from the October 1989 plunge. Nevertheless, Black Monday served as a grim reminder that the stock market moves in two directions.

3. Prognosis

Some observers have suggested that the sheer size of the public fund asset pool will lead to its inevitable regulation. Critics of this position generally believe that the diversity of plan design and regulation is necessary to meet divergent priorities of different localities and is the strength, not weakness, of what is collectively referred to as the State and local pension system. While State and local governments consistently have opposed Federal action, increased pressures to improve investment performance coupled with the call for responsible social investment may lessen some of the opposition of State and local plan administrators to some degree of Federal regulation. However, it is unlikely that Federal standards for public employee plans will get much serious Congressional consideration in the near future.

C. FEDERAL CIVILIAN EMPLOYEE RETIREMENT

1. Background

From 1920 until January 1, 1987, the Civil Service Retirement System (CSRS) was the staff retirement plan for all Federal civilian employees. That was changed with the creation of the Federal Employees Retirement System (FERS). CSRS covers all employees hired before January 1, 1984, who did not, by December 31, 1987, transfer to FERS. CSRS will cease to exist when the last employee in the system dies. FERS covers all Federal employees hired on or after January 1, 1984.

A key difference in the plans is that FERS benefits include Social Security, unlike CSRS. Enactment of the Social Security Amendments of 1983 implemented a recommendation of the 1981 National Commission on Social Security Reform and mandated Social Security coverage for all Federal employees hired on or after January 1, 1984. Social Security coverage of Federal employees compelled the Congress to consider additional retirement benefits for such employees and to examine various retirement options. The addition of Social Security coverage duplicated some CSRS benefits and would have increased combined employee tax contributions to more than 13 percent. Therefore, by Public Law 98-168 in 1983, Congress established an interim arrangement, pending enactment of a permanent new plan. After extended debate, the new plan was enacted in June 1986 as the Federal Employees' Retirement System Act of 1986 (P.L. 99-335).

(A) CIVIL SERVICE RETIREMENT SYSTEM

CSRS is the largest pension plan in the country, a pay-as-you-go system financed about one-fifth by employees' payroll taxes, one-fifth by the employer, and the balance from Federal general revenues. CSRS participants contribute 7 percent of total basic pay with no Social Security tax.

The annual cost of the CSRS system increased from $2.5 billion in 1970 to $29.2 billion in fiscal year 1989. The number of annuitants grew from 962,000 to an estimated 2.2 million during this same period. During the 1969–88 period, CSRS retirement benefits increased 197 percent, military retirement benefits 212 percent, and Social Security benefits 232 percent. During the same period the CPI for Urban Wage and Clerical Workers (CPI–W) increased 204 percent.

CSRS benefits structure is the following: after 5 years of service, vested benefits equal a percentage of the highest 3 years of pay; unreduced benefits at age 55 with at least 30 years of service; unreduced benefits at age 60 with at least 20 years of service; unreduced benefits at age 62 with at least 5 years of service; and credit for unused sick leave if employees continue to work until retirement. Payment of benefits for those who leave Federal service before they are eligible for retirement cannot start before age 62. Employees have the right to withdraw their own contributions without interest and forfeit all CSRS benefits. CSRS also provides disability and survivors benefits.

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) protects CSRS cost-of-living adjustments (COLAs) from sequestration under the Gramm-Rudman-Hollings Act. However, Congress can still mandate reductions or cancellations of the COLAs to meet budget deficit reduction targets. On January 1, 1990, a COLA of 4.7 percent was provided to retirees under CSRS.

Since 1987, a new Thrift Savings Plan (TSP) option has been available to CSRS participants which allows an employee to invest up to 5 percent of pay in a tax-deferred plan. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203) exempts the TSP from antidiscrimination rules which apply to similar tax-deferred plans in the private sector. Therefore, all CSRS participants will be able to contribute to TSP and will not face possible reduction of the allowable contribution rate, no matter what their income level. The Government makes no matching contribution to the CSRS TSP.

(B) THE FEDERAL EMPLOYEES RETIREMENT SYSTEM (FERS)

(1) Social Security Plus a Basic Defined Benefit Plan

The FERS plan is comprised of three tiers: a defined benefit plan, Social Security, and a Third Savings Plan. The FERS benefit plan is similar to private-sector plans. Workers retiring at age 62 or later with at least 20 years of service will receive an additional 0.1 percent of pay for each year of service. Unlike CSRS, unused sick leave cannot be used for computation of retirement benefits.

In contrast to CSRS, the FERS benefit is reduced for retirement before age 62. Unreduced benefits from FERS will be payable at age 62 with 5 years of service, at age 60 with 20 years of service, and at the minimum retirement age (MRA) with 30 years of service.

COLA's will be paid annually based on changes in prices as measured by the Consumer Price Index (CPI) except that regular retirees under age 62 will not receive any increase. The COLA will match the CPI increase up to 2 percent. If the CPI increase exceeds 2 percent, the COLA will be the greater of 2 percent or the CPI increase minus 1 percent. On January 1, 1990, a COLA of 3.7 percent was provided to FERS retirees.

(2) Employee Contributions

Unlike CSRS, employees participating in FERS are required to contribute to Social Security. The tax rate for Social Security coverage was 5.7 percent of pay in 1986 and 1987, 6.06 percent beginning in 1988, and 6.2 percent beginning in 1990 up to the taxable wage ceiling ($51,300 in 1990). The wage ceiling is indexed to the annual growth of wages in the national economy. In FERS, employees contribute the difference between 7 percent of basic pay and the Social Security tax rate which is 0.94 is 1988 and 1989, and 0.80 percent beginning in 1990.

At separation of service or retirement, employees have the option of withdrawing their own contributions to FERS in an actuarially reduced lump sum payment. For those not retiring, this choice means a relinquishment of the employer's contribution. When the lump sum is taken at retirement, it actuarially reduces the monthly retirement annunity the retiree and any surviving spouse will receive.

(3) Disability Benefits

Employees are eligible at any age for disability retirement after 18 months of creditable service if they are unable, because of disease or injury, to perform useful and efficient services in their current position or a vacant position at the same grade level in the same agency and commuting area. Employees applying for disability benefits under FERS may also apply for disability benefits under the Social Security system. Benefits will be based on the 3 highest years of pay and be offset, to an extent, by Social Security benefits.

(4) Survivor Benefits

The survivor benefit plan feature of FERS provides lump sum payments to all surviving spouses of workers who die before retirement plus, in some cases, annuities to the survivors. Survivors of retired workers are eligible for an annuity if the couple elects the survivor annuity plan. The survivor annuity plan may be waived only if the spouse provides written, notarized consent.

Children's survivor benefits under FERS are payable to surviving children until age 18, or until 21 if they are full-time students. Disabled children incapable of self-support may continue to receive benefits for life if the disability began prior to age 18. All children's benefits are offset by any Social Security benefits for which they are eligible.

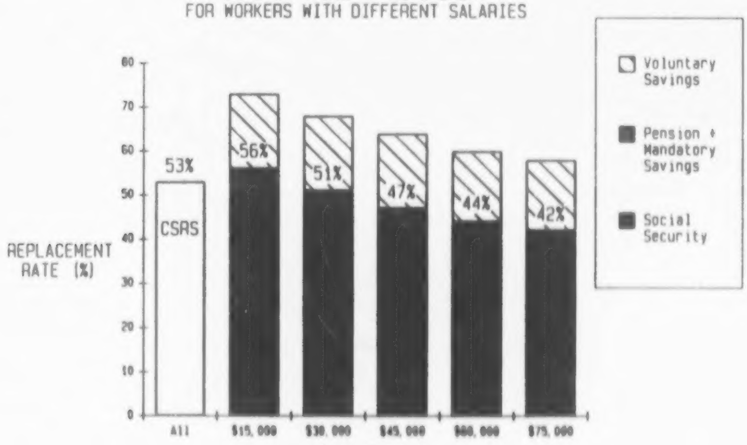
(5) Thrift Savings Plan (TSP)

FERS supplements the defined benefits plan and Social Security with a contribution plan that is similar to the 401(k) plans used by private employers. Employees accumulate assets in the TSP in the form of a savings account that either can be withdrawn in a lump sum or converted to an annuity when the employee retires. One percent of pay will be automatically contributed to the TSP by the employing agency. Employees will be permitted to contribute up to 10 percent of their salaries to the TSP. The employing agency will match the first 3 percent of pay contributed on a dollar-for-dollar basis and match the next 2 percent of pay contributed at the rate of 50 cents per dollar. The maximum matching contribution to the TSP by the Federal agency will equal 4 percent of pay plus the 1 percent automatic contribution. Therefore, employees contributing 5 percent or more of pay will receive the maximum employer match.

An open season will be held every 6 months to permit employees to change levels of contributions and direction of investments. Optional investment opportunities will be phased in over a 10-year period, including Government securities, fixed-income securities, or a stock protfolio. Employees are allowed to borrow from their accumulated TSP for the purchase of a primary residence, educational or medical expenses, or financial hardship.

CHART 1

BENEFIT VALUE AT RETIREMENT
FOR WORKERS WITH DIFFERENT SALARIES



NOTE: Assumes worker retiring in the year 2030 at age 62 with 30 years of service

SOURCE: Congressional Research Service, Report No. 86-137 EPW

2. Issues

(A) LUMP SUM WITHDRAWAL OF CONTRIBUTIONS

Public Law 99-335 contained a provision allowing those retiring under CSRS or FERS to withdraw at the time of their retirement their contributions to the system in exchange for a reduction in their annuity to reflect the withdrawn sum. The pension will be actuarially reduced so that over the retiree's lifetime the amount received as a monthly payment plus the withdrawal would be the same amount which would have been received if the withdrawal had not been made.

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101–239) changed the lump sum withdrawal rule for those retirees whose annuities begin after December 2, 1989, and before October 1, 1990. The change means that the lump sum will be payable to retirees in two installments, 50 percent at retirement and 50 percent 1 year after retirement. This change applies to both CSRS and FERS retirees.

(B) SOCIAL SECURITY PUBLIC PENSION OFFSET

Social Security benefits payable to spouses of retired, disabled, or deceased workers generally are reduced to take into account any public pension the spouse receives as a result of work in a Government job not covered by Social Security. The amount of the reduction equals two-thirds of the Government pension. In other words, $2 of the Social Security benefit is reduced for each $3 of the Government pension. The offset does not apply to workers whose Government job is covered by Social Security on the last day of the person's employment. Workers with at least 5 years of FERS coverage are not subject to the offset.

(C) SOCIAL SECURITY WINDFALL BENEFIT REDUCTION

Because the Social Security benefits formula treats workers with few years of covered earnings like low-income workers, Congress designed a special formula for persons with pensions from noncovered employment. The purpose of the provision contained in the Social Security Amendments of 1983 (P.L. 98–21) was to reduce the disproportionately high benefits ("windfall") that such workers would otherwise receive from Social Security. Public Law 100–647, the Technical Corrections and Miscellaneous Revenue Act of 1988, modified the formula by lowering the years of Social Security coverage required to exempt an individual from the windfall benefit formula from 30 to 25. Workers with 25 or more years of Social Security coverage are fully exempt from the reduction formula.

(D) TAXATION OF LUMP SUM PAYMENTS AT RETIREMENT

The Tax Reform Act of 1986 treats post-retirement lump sum payments of employee contributions the same as full annuity payments. That is, the value of the lump sum payment and the remaining annuity amount are combined and the proportionate shares of the employer's and employee's contributions are assessed. This rate is then applied to both the monthly annuity payments and the total lump sum payment.

The law places a penalty on the withdrawal of an employee's contributions in certain limited circumstances. The 10 percent penalty on early withdrawals from Individual Retirement Accounts (IRAs), except in cases of hardship, is extended to early withdrawals from qualified pension plans. This penalty affects Federal workers under age 55 who retire under early retirement provisions pertaining to job abolishments, reorganizations, reductions-in-force, or job categories which allow retirement at age 50 with 20 years of service. The withdrawal usually cannot be rolled over into an IRA or other qualified plan because it generally will not constitute 50 percent of the employee's lifetime annuity and therefore will not meet the IRS requirement for rollovers.

3. Prognosis

Congress is unlikely to make major changes in either CSRS or FERS in the foreseeable future. Some minor changes may be made in the Thrift Savings Plan to address unforeseen administrative needs of a large investment plan.

D. MILITARY RETIREMENT

1. Background

For more than four decades following the establishment of the military retirement system at the end of World War II, the retirement system for servicemen remained virtually unchanged. However, the enactment of the Military Retirement Reform Act of 1986 (P.L. 99-348), brought major reforms to the system. The Act affected the future benefits of servicemembers first entering the military on or after August 1, 1986. As a participant only becomes vested in the military retirement program after 20 years of service, the first retirees affected by the new law will be those with 20 years of service retiring on August 1, 2006.

In 1987, 1.6 million retirees and survivors received military retirement benefits. For fiscal year 1988, total Federal military retirement outlays have been estimated at $18.9 billion. Three types of benefits are provided under the system: Standard retirement benefits, disability retirement benefits, and survivor benefits under the Survivor Benefit Program (SBP). With the exception of the SBP, all benefits are paid by contributions from the employing branch of the armed service, without contributions by the participants.

Servicemembers who retire from active duty receive monthly payments based on a percentage of their retired pay computation base. For persons who entered military service before September 8, 1980, the computation base is the final monthly base pay being received at the time of retirement. For those who entered service on or after September 8, 1980, the retired pay computation base is the average of the highest 3 years of base pay. Base pay comprises approximately 65-70 percent of total pay and allowances.

Retirement benefits are computed using a percentage of the retired pay computation base. The retirement benefit for someone entering military service prior to August 1, 1986, is determined by multiplying the years of service by a multiple of 2.5. Under this formula, the minimum amount of retired pay to which a retiree is entitled after a minimum of 20 years of service is 50 percent of base pay. A 25-year retiree receives 62.5 percent of base pay, with a 30-year retiree receiving the maximum—75 percent of base pay.

The Military Reform Act of 1986 (P.L. 99-348) changed the computation formula for military personnel who enter military service on or after August 1, 1986. For retirees under age 62, retired pay will be computed at the rate of 2 percent of the retired pay computation base for each year of service through 20, and 3.5 percent for each year of service from 21 through 30. Under the new formula, a 20-year retiree under age 62 will receive 40 percent of his or her basic pay, 57.5 percent after 25 years, and 75 percent after 30 years. Upon reaching 62, however, all retirees have their benefits recomputed using the old formula. The changed formula, therefore, favors the longer serving military careerist, providing an incentive to remain on active duty longer before retiring. Since most military personnel retire after 20 years, the cut from 2.5 percent to 2 percent will cut program costs. These changes in the retired pay computation formula apply only to active duty nondisability retirees. Disability retirees and Reserve retirees are not affected.

Benefits are payable immediately upon retirement from military service, regardless of age and without taking into account other sources of income, including Social Security. By statute, all benefits are fully indexed for changes in the Consumer Price Index (CPI). In the event of an across-the-board budget cut under the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings), military retirement cost-of-living adjustments (COLA's) are exempt from sequestration. Under the Military Retirement Reform Act of 1986, however, COLA's will be held at 1 percentage point below (CPI) for military personnel beginning their service after August 1, 1986.

2. Issues

(A) COST

The military retirement system repeatedly has been criticized for providing lavish benefits, costing too much, and contributing to inefficient military personnel management. The Military Retirement Reform Act of 1986 was enacted in response to these opinions. The Act's purpose was to contain the costs of the military retirement system and provide incentives for experienced military personnel to remain on active duty.

Approximately 1.5 million retired officers, enlisted personnel, and their survivors received nearly $18.9 billion in annuity payments in 1987. At the current rate of growth, this expenditure will reach an estimated $45 billion annually by the end of the century. In 1986, military retirees received an average of $12,671 in annuities.

In particular, four identifiable features of the military retirement system greatly contribute to its cost:

(1) Full benefits begin immediately upon retirement; the average retiring enlisted member begins drawing benefits at 42, the average officer at 46. Benefits continue until the death of the participant.

(2) Military retirement benefits are indexed for inflation.

(3) The system is basically noncontributory, although in order to provide survivor protection, the participant must make some contribution.

(4) Military retirement benefits are not integrated with Social Security benefits.

Supporters of the current military retirement scheme have identified several characteristics arguably unique to military life that they feel justify relatively more liberal benefits to military retirees than other Federal retirees:

(1) All retired personnel are subject to involuntary recall in the event of a national emergency; retirement pay is ostensibly part compensation for this exigency.

(2) Military service places different demands on military personnel than civilian employment, including higher levels of stress and danger, and more frequent separation from family.

(3) The benefit structure has provided a significant incentive for older personnel to leave the service and maintain "youth and vigor" in the armed services. In this respect, it has been largely successful. Almost 90 percent of military retirees are under age 65, 50 percent under the age of 50.

Military personnel do not contribute to their retirement benefits, though they do pay Social Security taxes and offset a certain amount of their pay to participate in the Survivor Benefit Program. Only a small minority of the studies conducted in the past decade have recommended contributions by individuals. As a result, no refunds of contributions are available to those leaving the military before the end of 20 years. And the full cost of the program appears as an agency expense in the budget, unlike the civilian retirement system where one-fifth of the cost is paid by employee contributions.

Finally, since the beginning of Social Security coverage for military personnel in 1945, military retirement benefits have been paid without any offset for Social Security. Taking into account the frequency with which military personnel in their middle forties retire after 20 years of service, it is not unusual to find them retiring from a second career with a pension from their private employment along with their military retirement and a full Social Security benefit. Lack of integration of military retirement and Social Security benefits generally adds to the perception that military retirement benefits are overly generous.

Military retirement is fully indexed for inflation, a feature that retirees traditionally have considered central to the adequacy of retirement benefits. In recent years, full indexing of military and other Federal retirement benefits has become the object of most deficit-reduction measures. As a result of the original provisions of the Gramm-Rudman-Hollings Act, the 1986 military retiree COLA was cancelled. Since that time, however, legislation was enacted that excluded the COLA from sequestration.

(B) RETIREMENT ADEQUACY

The temptation to use strict economic arguments in comparing military pensions to those found in the private sector is difficult to avoid, especially absent any immediate threat of war. The pivotal issue in evaluating the military retirement system, however, is not cost, but the system's ability to provide adequate retirement income to those men and women who serve in the armed forces. Several recent studies of the military retirement system have suggested that the 20-year service requirement is unfair to the majority of military personnel. Nearly 65 percent of officers and 90 percent of enlisted personnel leave before completing the requisite 20 years of service. It has been suggested that this design is likely to prolong the careers of marginal military personnel beyond their usefulness, while simultaneously providing an incentive for highly skilled and experienced personnel to leave the armed services for second careers as soon as they complete 20 years of service, in order to capitalize on private sector employment opportunities and pensions. The result is a system that pays relatively high benefits to a disproportionately high number of officers when compared to the composition of the military as a whole.

Commentators periodically have called for shorter vesting schedules, comparable to those required for private plans under ERISA or for the Federal service jobs. Some military manpower experts have argued that such a change would adversely impact the ability to maintain a vigorous and youthful military force. On the other hand, some military manpower analysts argue that the need for youth and vigor is overstated in view of new technologies that put a premium on technical skills rather than physical endurance.

(C) THE MILITARY SURVIVOR BENEFIT PLAN

The Military Survivor Benefit Plan (SBP) was created in 1972 by Public Law 92-425. Under the plan, a military retiree can have a portion of his or her retired pay withheld to provide a survivor annuity to a spouse, spouse and child, child only, person with an "insurable interest," or a former spouse. As a result of the SBP, a military retiree can provide for an annuity of up to 55 percent of his or her total retired pay at the time of death to be paid to a surviving spouse. Upon reaching age 62, the SBP annuity automatically is reduced to 35 percent of military retired pay for all surviving spouses. This offset occurs regardless of whether the survivor is eligible for Social Security retirement or survivors benefits and regardless of any other sources of income available to the surviving spouse.

A retiree automatically is enrolled in the plan upon retirement at the maximum rate unless he or she chooses, in writing, not to participate or to do so at a lesser level of protection. If such a choice is made, the spouse must be notified. SBP annuities are adjusted for the cost-of-living on the same basis as military retired pay. No coverage reductions were made by the Military Reform Act. However, SBP benefits will be subject to the changes made in the formula for determining cost-of-living adjustments.

(1) Survivor Social Security Offset

Coverage of military service under Social Security entitles the surviving spouse of a military retiree to receive Social Security survivor benefits based on the deceased retiree's active duty military service. The Military Survivor Benefit Plan is integrated with Social Security. Since the original intent of the SBP was to provide a portion of the deceased military member's retired pay to the surviving spouse, it was considered appropriate that all sources of survivor benefits attributable to military service be included in the survivor benefit computation. As a result, Social Security survivor benefits payable because of military service were subtracted from the SBP so that the SBP and Social Security together would provide 55 percent of the retired pay to the surviving spouse.

(2) The Two-Tiered SBP

Some have questioned the equity of the SBP. Military SBP benefits become payable immediately upon the death of the retiree, regardless of the age of the surviving spouse. Social Security widow(er)'s benefits are not paid until the survivor reaches age 60, while retirement benefits for a spouse with their own earnings record do not begin until age 62.

Under the "two-tier" system, if the surviving spouse is, for example, age 57 at the time of a retiree's death, full SBP benefits are payable immediately, and will continue until the survivor reaches age 62. Surviving spouses without their own Social Security earnings record are able to draw full benefits for several years before having them reduced. However, survivors who will receive their own retirement benefits from Social Security must wait for them until age 62, the point at which their SBP annuity is reduced. For survivors who are not eligible for any Social Security benefits, SBP annuities will be reduced even if they do not have additional retirement income when they reach age 62.

This difference in treatment of survivors may lead to future legislative activity. Although the "two-tier" SBP does provide certainty as to benefits payable, the fact that it may result in less than optimal targeting of limited Federal funds makes it ripe for further changes as Congress continues to wrestle with mounting deficits.

(3) Cost-of-Living Adjustment

Military retirees, along with Social Security and other Federal retirees, received a 4 percent COLA effective January 1, 1989. The President's budget submission for fiscal year 1990 proposes that the January 1990 COLA be eliminated, which would result in a $620 million cut in benefits. Also, in 1991, the President's budget would hold COLA's to 1 percent below the rate of inflation.

3. PROGNOSIS

In 1989, the issue which will undoubtedly generate controversy and hence receive Congressional attention will be the President's proposed elimination of the January 1990 COLA for military retirees. Without the COLA, military retirees would receive an estimated $620 less in benefits that year. In addition, military retirees can be expected to actively oppose the proposal in the President's budget to begin charging a user fee for the provision of medical care at military hospitals. As for other issues, interest will likely continue about the current system's inequities, but no major legislative changes are anticipated in the immediate future.

E. RAILROAD RETIREMENT SYSTEM

1. BACKGROUND

The Railroad Retirement System is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with Social Security. The system was authorized in 1935, prior to the creation of Social Security, and remains the only federally administered pension program for a private industry. It covers all railroad firms and distributes retirement and disability benefits to employees, their spouses, and survivors. Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of vested so-called "dual" or "windfall" benefits, which are paid with annually appropriated Federal general revenue funds through a special account.

In fiscal year 1988, railroad retirement, disability, and survivor benefits totalled $6.7 billion. There was a total of 925,100 retirement, disability, and survivor beneficiaries, receiving the following average monthly benefits according to the categories listed below.

Type of benefit	Number	Amount/month
Age 65 or over	3,000	$628
Age 60 to 64, unreduced	5,000	1,339
Age 60 to 64, reduced	8,500	923
Age retirements, total	16,500	996
Disability retirements	4,800	1,089
Regular employee annuities, total	21,300	1,017
Unreduced spouse annuities	10,600	392
Reduced spouse annuities	6,700	328
Divorced spouse annuities	400	193
Spouse and divorced spouse annuities, total	17,800	363
Aged widow(er)s	13,500	544
Disabled widow(er)s	400	506
Widowed mothers and fathers	400	478
Remarried widow(er)s	600	325
Divorced widow(er)s	800	376
Children	1,300	484
Parents	(1)	409
Survivor annuities, total	17,000	521
Total	56,100	
Lump-sum death payments	8,100	840
Residual payments	300	4,949
Total	8,400	

Source: RRB and its January 1989 Information Conference Handbook, p. 17

The highest individual annuity awarded in 1988 was $1,662. The highest combined retiree and spouse annuities awarded in 1988 totalled $2,432.

2. ISSUES

(A) THE STRUCTURE OF THE RAILROAD RETIREMENT SYSTEM

In the final quarter of the 19th century, railroad companies were among the largest commercial enterprises in the Nation and were marked by a high degree of organizational centralization and integration. As first established in 1934, the railroad retirement system was designed to provide annuities to retirees based on rail earnings and length of service. However, the present railroad retirement system was a result of the Railroad Retirement Act of 1974, which fundamentally reorganized the program. Most significantly, the Act created a two-tier benefit structure in which Tier I was intended to serve as an equivalent to Social Security and Tier II as a private pension.

Tier I benefits of the railroad retirement system are computed on credits earned in both rail and nonrail work, while Tier II is based solely on railroad employment. The total benefit continued traditional railroad annuities and eliminated duplicate Social Security coverage for nonrail and rail employment.

The second Reagan Administration consistently attempted to dismantle the railroad retirement system, proposing to convert to a private pension administered by a private corporation all benefits in excess of Social Security, and turning over to Social Security the Social Security-equivalent benefits of the system. The Administration's rationale was that the Government should not administer an industry pension, and that given the intended equivalency of Tier I and Social Security, it was appropriate for Social Security to absorb the Social Security equivalent benefits. Nonetheless, each Congress during that period rejected the proposal on the grounds that it could lead to a cut in benefits for present and future retirees and undermine confidence in the system. It was further argued that such a conversion would compound the agency's administrative burden.

(B) RECENT FINANCING PROBLEMS

(1) The 1983 Retirement Fund Crisis

Because railroad retirement benefits are financed by payroll tax revenues, the number of rail employees has always been a crucial factor in determining the financial viability of the system. Through the late 1970's, the rail industry was financially troubled, with falling rail traffic and employment opportunities. As a result, payroll tax revenues declined, leaving inadequately funded the 60–30 early retirement benefit (which allows workers with at least 30 years of experience to retire at age 60 with full Tiers I and II benefits as if 65) initiated by the 1974 law and the vested "dual" benefit. By 1980, the retirement trust fund was faced with financial difficulties and cash-flow problems.

Since the end of World War II, the worker/beneficiary ratio has been decreasing, as noted in the following table:

EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945

[In thousands]

	Average employment	Beneficiaries	Ratio of workers to beneficiaries
Year:			
1945	1,680	210	8.04
1950	1,421	461	3.08
1955	1,239	704	1.76

EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945—Continued

[In thousands]

	Average employment	Beneficiaries	Ratio of workers to beneficiaries
1960	909	883	1.03
1965	753	930	.81
1970	640	1,052	.61
1975	548	1,094	.50
1980	532	1,084	.49
1981	503	999	.50
1982	440	988	.44
1983	395	981	.40
1984	395	980	.40
1985	372	954	.39
1986	342	941	.36
1987	320	928	.34
1988	302	915	.34

Source: Railroad Retirement Board, 1986, Annual Report, dated October 23, 1987.

The 1980 long-term financing problem worsened because Congressional appropriations for "windfall" benefits were far from sufficient to pay for those benefits that year, and appropriations shortfalls consequently were paid from the railroad retirement trust fund. At the same time, funding for the 60-30 early retirement benefits had not been improved.

To improve the system's financial condition, Congress included a number of provisions in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) and the Economic Recovery Tax Act of 1981 (P.L. 97-34). Those provisions raised payroll taxes on employers and employees, modified benefits, created a separate account for windfall benefits, and provided the railroad retirement trust fund with authority to borrow from the General Treasury when near-term cashflow difficulties arise.

Unfortunately, in the final quarter of 1982, an economic recession devastated the railroad industry and thwarted the intended benefits of the 1981 laws, bringing the railroad retirement system to the brink of insolvency and threatening a 40-percent cut in 1983 Tier II benefits. Another financial drain on the fund stemmed from borrowing from the fund by the Railroad Unemployment Insurance Account. By 1983, those unpaid borrowings totaled $575 million.

In 1983, rail labor and management, following Congressional instructions, collectively negotiated a comprehensive rescue package and submitted it to Congress. As enacted in the Railroad Retirement Solvency Act of 1983 (P.L. 98-76), the package was composed of payroll tax increases, benefit reductions, and general revenue contributions, and was designed to ensure the solvency of the railroad retirement system through the 1990's, even under pessimistic employment assumptions. In the short-run, passage of the measure averted the threatened 40-percent reduction in Tier II benefits scheduled for 1983. Key provisions of the Act include:

(1) A COLA offset which required that the next 5 percent of Tier I (both rail and nonrail credits) COLA increases be subtracted, dollar for dollar, from Tier II (pension) benefits. This

effectively eliminated the 3.5 percent COLA scheduled for 1984 and reduced the 1985 COLA from 3.5 percent to 2 percent. That COLA offset provision applied only to beneficiaries on the rolls before January 1, 1984, and was estimated to reduce their Tier II benefits by a total of $920 million through fiscal year 1988. The effect of that Tier II benefit cut is compounded over the life of the beneficiary.

(2) The 60-30 early retirement unreduced benefit, which allowed employees with at least 30 years of service to retire at age 60 with full Tiers I and II benefits as if 65, was reduced to a 62-30 early retirement full benefits rule and a 60-30 reduced Tier I benefit rule. The reduced 60-30 early retirement Tier I benefit remains frozen in amount until the retiree reaches age 62. At age 62, the reduced Tier I benefit is recomputed, not as a 62-30 full early retirement benefit, but to reflect increases in national wage levels. (The law did not change the 60-30 early retirement full Tier II benefits.)

(3) Three annual Tier II payroll tax increases of 0.75 percent were levied on rail employees, and three annual payroll tax increases of 1 percent were levied on rail employers. This raised total payroll taxes from 13.75 percent to 19 percent—from 2 to 4.25 percent the employee rate and from 11.75 to 14.75 percent the employer rate.

(4) The wage base on which the employer-paid railroad unemployment insurance tax is levied was increased by 50 percent from the first $400 of monthly earnings to the first $600. A temporary unemployment tax was levied on employers on July 1, 1986, to repay the unemployment account debt to the retirement fund.

(5) Tier II benefits and vested dual benefits were subjected to Federal income taxation under the same guidelines as private pension earnings to the extent the pension income exceeds the employee's contributions. The revenues collected from this tax were to be transferred to the rail trust fund to finance benefit payments through October 1, 1988. After that, the revenues remain with the Federal Treasury. (Tier I benefits were made subject to the Federal income tax, the same as Social Security benefits, by the Social Security Act Amendments of 1983, P.L. 98-21.)

(2) The 1986-87 Fund Crisis

Following enactment of the Railroad Retirement Solvency Act of 1983, there was optimism that the retirement fund finally was on a firm financial foundation and that the decline in rail industry employment that had threatened the system would level off. In 1985, the Railroad Retirement Board (RRB) forecasted that the even substantial declines in rail employment would not bring about cash-flow problems in the next 10 to 20 years. However, the RRB did characterize the fund's long-term stability "still questionable."

Because the Tier II tax had not been increased and rail employment continued to decline, the chief actuary's 1987 report recommended that the Tier II tax be increased 4.5 percent, effective January 1, 1988. The report projected possible cash-flow problems as early as 2001, under pessimistic assumptions and the present financing structure. To address these concerns, the report also recommended that a panel be formed to examine possible sources of revenue for the system.

In response, the Omnibus Budget Reconciliation Act of 1987 (1987 OBRA), Public Law 100-203, increased the employer Tier II tax from 14.75 to 16.1 percent and the employee Tier II tax from 4.25 to 4.9 percent, on wages up to $33,600, effective January 1, 1988. The estimated revenue from those tax increases was: $144 million in 1988, $182 million in 1989, and $183 million in 1990. In addition, the Act increased revenue to the fund by an estimated additional $400 million by extending from October 1, 1988, to October 1, 1989, the cut-off date for transfer to the fund of revenue from the income taxation of Tier II and windfall benefits and removing the $877 million cap on such transfers. Acting on the recommendation in the 1987 report of the RRB's chief actuary, the Act also authorized the establishment of a Commission on Railroad Retirement Reform to report to the Congress on possible solutions to the system's long-term financial problems. The Reform Commission's report is to be submitted to the Congress by October 1, 1990.

(3) Current Actuarial Status

The 1986 and 1987 annual reports of the RRB were not rosy, recommending that the Congress take immediate steps to increase revenue to the system. However, the 1988 report paints a much more favorable financial picture, due to the establishment of the Commission on Railroad Retirement Reform, the revenue increases to the system under the 1987 OBRA, and the increase in the tax rates for the Unemployment Repayment Tax. No recommendations for immediate revenue increases are contained in the 1988 report.

(C) THE RAILROAD UNEMPLOYMENT INSURANCE ACCOUNT DEBT

(1) The Consolidated Omnibus Budget Reconciliation Act of 1985

Prior to the 1983 Railroad Retirement Solvency Act, there were no requirements for repayment of the debt to the retirement fund. The debt was to be paid, in whole or in part, only if excess funds were available in the unemployment fund. The Act instituted the first tax for repayment of that debt.

Provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (1985 COBRA), enacted as Public Law 99-272, increased the rates of that tax to 4.3 percent, 4.7 percent, and 6 percent for 1986, 1987, and 1988, respectively, under the 1983 Act. The 1985 Act did not change the 2.9 percent rate or the 3.2 percent rate for 1989 and 1990, respectively, under the 1983 Act.

Revenue from the repayment tax can be used only for repayment of the debt incurred prior to September 30, 1985, plus interest, and is scheduled to expire on September 30, 1990. It is estimated that the unpaid balance on that date would be about $600 million. In fiscal year 1987, payments on the debt totalled $182.9 million, consisting of $138.6 million on principal and $44.3 million in interest. At the end of that fiscal year, the debt, including accrued interest, totalled $744.6 million.

(2) The Technical and Miscellaneous Revenue Act of 1988

In 1988, Congressional concerns over the debt in the railroad retirement fund led to the enactment of a number of provisions in the Technical and Miscellaneous Revenue Act of 1988, enacted as Public Law 100-647. First, the Act increased the repayment tax rate to 4 percent, effective 1989, until the debt incurred prior to October 1, 1985, with interest, is repaid. Second, a new surcharge tax schedule was instituted—namely, 1.5 percent when the unemployment account's net assets fall below $100 million, 2.5 percent if less than $50 million, and 3.5 percent if below zero. Third, the Act required the RRB to submit a report to the Congress on July 1 of each year, commencing in 1989, on the status of the railroad unemployment insurance system.

(D) TAXATION OF RAILROAD RETIREMENT BENEFITS

(1) Taxation of Tier I

(a) The Social Security Act Amendments of 1983

In the Social Security Act Amendments of 1983, enacted as Public Law 98-21, the Congress acted on a labor-management recommendation that Tier I benefits be subject to the same taxation as Social Security benefits. Consequently, the amount subject to tax is one-half of the excess of the total of adjusted gross income, plus one-half of the total Tier I benefits for the year, plus nontaxable interest income over the base of $25,000 for an individual ($32,000 for joint filers), not to exceed one-half of total Tier I benefits for that year. (Adjusted gross income does not include Tier I benefits.)

As an example, for an individual with an adjusted gross income of $20,000, $6,000 in Tier I benefits, and $3,000 in tax-exempt interest income, the computation would be $20,000 plus $3,000 (half of the Tier I benefit) plus $3,000 (the tax-exempt interest income) minus $25,000 (the base amount for single filers), yielding $1,000. The amount of Tier I benefits subject to tax is one-half of $1,000, or $500.

In 1987, 9.014 million returns reported a total of $74.2 billion in Social Security benefits. Approximately 3.3 million of those returns had a total of $11.7 billion of Social Security benefits in taxable income, an average of $3,260 of Social Security benefits per return.

(b) The Railroad Retirement Solvency Act of 1983

The Railroad Retirement Solvency Act of 1983, Public Law 98-76, established the Social Security Equivalent Benefit Account (SSEBA), under the Railroad Retirement System, separate from the Railroad Retirement Account (RRA). The Report of the Office of Tax Analysis explains SSEBA as follows: "From the SSEBA, retired rail workers receive the amount of Tier I benefits equivalent to the Social Security benefits they would have received had their service been covered under the Social Security system rather than the Railroad Retirement System. The tax liability of the Social Security-equivalent benefits is transferred to the SSEBA. The remainder of Tier I benefits is paid from the Railroad Retirement Account with the tax liability for this portion transferred to the Railroad Retirement Account. In 1985, the first full year in which taxes on the Tier I benefits were divided between the two accounts, 84 percent were classified as SSEBA payments, with the remaining 16 percent classified as RRA benefits" and, therefore, in excess of Social Security equivalent benefits.

(c) The Consolidated Omnibus Budget Reconciliation Act of 1985

The Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, restricted the Social Security income tax formula to only the part of a Tier I benefit equivalent to the amount of the SSEBA. The Act made the part of a Tier I benefit in excess of the non-SSEBA subject to same tax as Tier II and all private pensions, effective the 1986 tax year. The rationale for the change was that as the rail employee Tier I tax is the same as the employee Social Security tax, the retired rail employee should not have a greater income tax advantage than the Social Security beneficiary.

The non-SSEBA is funded by employees' and employers' Tier II tax contributions, the same as are Tier II benefits. As a result, the RRB must annually make the necessary calculations to enable it to inform each annuitant of the amount of the Tier I benefit that is equivalent to Social Security and the amount, if any, that is in excess of the non-SSEBA. For fiscal years 1988 through 1993, the RRB has made the following projections of the respective SSEBA and non-SSEBA:

	SSEBA (billions)	non-SSEBA (millions)
Fiscal year:		
1988	3.94	568
1989	4.11	571
1990	4.26	585
1991	4.41	591
1992	4.54	584
1993	4.61	587

The RRB estimates that the change in taxation will generate an additional $40 million in revenues each year. Under the 1987 Act, these additional revenues will be credited to the RRA account until October 1, 1989, the same as are revenues from the taxation of Tier II benefits.

(2) Taxation of Tier II Benefits

The labor-management negotiated recommendation for the taxation of Tier II benefits was implemented by the 1983 Solvency Act (P.L. 98-76). However, before final passage, the original bill was amended to deny Tier II annuitants "a fresh start." The tax became effective with the 1984 tax year, with all Tier II benefits received before 1984 charged against the recovery of the annuitant's tax contributions to the benefit, even though the benefits were tax-exempt under the tax law when they were received. That increased the income tax liability of Tier II annuitants who had retired before 1984.

The Tax Reform Act of 1986 (P.L. 99-514), eliminated the 3-year rule for the recovery of private pension contributions, including the employee Tier II tax. Under that rule, the pension benefits did not become taxable until the total contribution of the annuitant was recovered in benefits over an initial period not to exceed 3 years. Under the 1986 change, the non-SSEBA portion of Tier I benefits and all of Tier II benefits become taxable immediately upon receipt, but on a prorated basis as to the annuitant's contributions, taking into consideration the life expectancy of the annuitant. The same rule applies to all private pensions.

Under the 1983 Solvency Act vested "dual" benefits have been subject to income tax the same as Tier II benefits, effective the 1984 tax year.

(E) BENEFIT FORMULAS, QUALIFICATION RESTRICTIONS AND LIMITATIONS

(1) "Last Person Service" Rule

Perhaps the most troublesome qualification rule was the "last person service" rule, which required a retiree to give up a job (full or part-time) outside the rail industry to be eligible for an annuity. That rule became even more problematic in recent years because to reduce employment many railroad employers instituted combined early retirement and separation pay plans applicable to employees who would not be eligible for railroad retirement benefits for many years after leaving that employment. Many former rail employees found satisfactory jobs in other industries, only to learn that they had to give up that employment to collect those benefits upon reaching the prescribed age. Under the rule, they could quit that job and apply for the benefits, then go to work for another employer (but, not a railroad) and continue to receive the benefits, subject to the applicable earnings limitations. However, they could not return to work for the last non-railroad employer immediately preceding the application for benefits. This restriction applied to the spouse benefit as well as the retiree's benefit, part-time employment as well as full-time employment.

As a result of provisions enacted in the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), the "last person service" rule was replaced with a new rule, one which reduces the Tier II benefit by an amount equal to 50 percent of earnings from the last non-railroad employer, subject to the limitation that the total reduction in Tier II plus supplemental annuity benefits cannot be more than 50 percent. The new rule continues to apply at age 70 and beyond, but does not affect Tier I. In post-retirement employment, Tier I is affected only by the earnings limitations and the prohibition against railroad employment.

(2) Earnings Limitations

Tier I and vested dual benefits are subject to the same earnings limitations as Social Security: $1 deduction for each $2 earned over the limit. For 1989, the maximum earnings limits for the 65-69 age group are $8,880 (1988—$8,400), and $6,480 for those under 65 (1988—$6,120). The estimated limit amount for 1990 for the 65-69 age group is $9,120. From age 70 on, there is no earnings limitation.

During the first year of benefits only, the earnings limits are applied on a monthly basis only in those months in which the amount earned exceeds one-twelfth of the annual limit for that year. After the first year, the limits are applied to total annual earnings, without regard to either the number of months worked or the amount earned in any 1 month.

Those earnings limitations do not apply to Tier II, nor, in all cases, to all of Tier I. The earnings deduction cannot reduce the Tier I amount to an amount less than the Tier I amount would be, if computed only on the annuitant's railroad service through December 31, 1974. Also, the non-SSEBA portion of a Tier I benefit is not subject to a reduction for earnings over the limit.

In 1990, the deduction will change to $1 for each $3 earned over the limit for the 65–69 age group. For the 62–64 age group, the deduction will remain $1 for each $2 earned over the limit.

Any railroad retiree contemplating returning to work should first ask the RRB's district office for a computation of the amount of the Tier I benefit that would not subject to reduction for excess earnings.

Opponents of the earnings limitations claim it discourages the elderly from working and discriminates against those who need the additional income most—namely, those with lower-than-average Social Security benefits. Conversely, those receiving the highest benefits can earn the same amount, without penalty.

A January 1989 Labor Department report, entitled "Older Worker Task Force: Key Policy Issues for the Future", cites that 61 percent of workers 63 and older are working because they "need the money." The report also points out that the "earnings test hurts those who must rely on earned income to supplement retirement income but does not affect those who have substantial income from savings." In 1986, according to the Labor Department, 48 percent of the males and 61 percent of the women 65 and older were working part-time. However, those statistics do not reveal what percentage of each group was working because they needed the income, nor the percentage who would prefer to work full-time.

Although bills were pending in the 100th Congress to repeal or phase-out the Social Security earnings limitations, no final action was taken on that legislation. No doubt the 101st Congress will see a renewal of efforts to repeal, phase-out, or otherwise modify, the Social Security earnings limitations. (For additional discussion of this issue, please see the Social Security chapter.)

(3) Social Security "Notch"/Railroad Retirement "Notch"

Legislation in the 100th Congress to adjust the Social Security benefit formula for retirees born between 1917 and 1928 to eliminate the so-called "notch" benefit disparities would benefit railroad retirees as well as Social Security beneficiaries born in those years.

In the 100th Congress, the Special Committee on Aging and the House Ways and Means Subcommittee on Social Security, each held a hearing on this issue. However, the Congress did not take any final action on notch legislation.

There seems to be no dispute that a result of the 1972 amendments followed by the 1977 amendments to the Social Security Act was comparatively lower benefits for those born after 1916 than for those born before 1917. Supporters of the "corrective" legislation claim that this result was not intended by Congress and that the benefits of that group should be increased to bring their benefits more in line with the benefits of the group born before 1917. Proponents claim that the notch has already affected almost 10 million retirees, and that each year about 1.6 million new retirees born in the 1920's will experience the notch. On the other hand, opponents of the proposed legislation contend that the pre-1917 group are getting an unintended "bonanza," that the post-1916 birth group are receiving what was intended, and that "corrective" legislation would be too costly.

A 1988 General Accounting Office (GAO) Report on "The Notch Issue" concluded, among other things, that "Additional payments . . . through 1996 could range from about $20 billion to over $300 billion. Using current trust fund balances to finance notch remedies would slow attainment of minimum contingency reserve levels and could put the system at additional risk should there be an economic downturn. Also, in comparing the notch with patterns of income, assets, and health status, retirees likely to experience larger disparities have, on average, higher incomes and more assets. Those who tend to be in poorer health are more likely to experience smaller benefit disparities."

The GAO study also points out that: "Under 1983 legislation, current workers (who would be taxed to pay higher benefits to notch beneficiaries) already pay higher taxes than would be necessary under the pay-as-you-go concept to partially fund their own future benefits and reduce future workers' tax burden. Imposing additional taxes on these current workers to finance a higher replacement rate for the notch group (many of which already receive a higher replacement rate than can be anticipated by current workers) would raise significant issues of equity."

Nevertheless, as long as enough Social Security beneficiaries believe they are being victimized by notch, there likely will be legislative proposals in the Congress to address this issue. (For further discussion of this issue, please see chapter 1.)

(F) THE 1988 REDUCTION IN THE DUAL BENEFIT

Under current law, payment of the "dual" benefit depends on an annual appropriation by Congress from the General Treasury. If the amount appropriated for a particular year is not sufficient for payment of the benefit in full for that year, the RRB must reduce the benefit payments accordingly.

That occurred in fiscal year 1988. As a result of the "Budget Summit" agreement between Congress and the Administration, providing for an across-the-board budget cut, for that fiscal year, dual benefits were reduced. That agreement was implemented by the Continuing Resolution for fiscal year 1988 (P.L. 100-202), enacted December 22, 1987.

Because of the resulting appropriation shortfall for the dual benefit payment account, the RRB made the 1-year reduction in dual benefit payments in the six monthly payments on April 1, 1988, through September 1, 1988. The appropriated for fiscal year 1989 is sufficient to finance monthly payments in full for that period.

(G) THE 1987 COMMISSION ON RAILROAD RETIREMENT REFORM

To address the long-term financing concerns of the railroad retirement system, provisions in the Omnibus Reconciliation Act of 1987, Public Law 100-203, authorized the establishment of a Commission on Railroad Retirement Reform. The Act called for a seven-member commission, to include four members appointed by the President (one recommended by rail labor, one by rail management, one by commuter railroads, and one representing the general public), one public member appointed by the president pro tempore of the Senate, one public member appointed by the Speaker of the House, and one public member appointed by the Comptroller General. By early 1989, a fully appointed membership was ready to commence its work.

Specifically, the Reform Commission's mandate is to conduct a study of the railroad retirement system's short-term and long-term solvency and to recommend to the Congress revisions to the system to assure the provision of retirement benefits to former, present, and future railroad employees on an actuarially sound basis. The financing revisions the Reform Commission are to examine include the advisability of restructuring the financing of railroad retirement benefits through increases in the Tier II tax rate, increasing the Tier II tax wage base, imposing a tax on operating revenues, revising in the investment policy of the railroad retirement pension fund, and establishing a privately funded and administered railroad industry pension plan.

The Reform Commission's study is to be submitted to the Congress by October 1, 1990.

3. Prognosis

No substantive structural changes in the railroad retirement system are likely before the 102d Congress because the Reform Commission's report is not due until October 1, 1990. If any railroad retirement benefits become an issue in the 101st Congress, the issue likely will be raised by the budget process in connection with efforts to reduce the Federal deficit.

As of early 1989, the Bush Administration was seriously considering retaining a number of railroad retirement proposals in the Reagan budget proposal for fiscal year 1990. Included was a proposal to shift from the Federal Treasury to the rail industry 25 percent of the annual cost of "the Federal Subsidy" for the dual benefit. Under current law, all of those benefits are paid out of the Federal Treasury. In addition, the Fiscal Year 1990 Reagan budget proposed to pay uniform rail pension COLA's for all non-Social Security equivalent benefits. That would mean that the non-SSEBA portion of Tier I would receive the same COLA as Tier II, 32.5 percent of the Tier I SSEBA COLA.

In addition, other railroad retirement proposals may be included in the report of the National Economic Commission, established under Public Law 190-203, "to reduce the Federal budget deficit while promoting economic growth and encouraging saving and capital formation." The report is due March 1, 1989.

Chapter 3

TAXES AND SAVINGS

OVERVIEW

In both design and application, the Federal tax code long has reflected a recognition of the special needs of older Americans. Helping to preserve a standard of living threatened by reduced income, the loss of earning power, and increases in nondiscretionary expenditures has been a primary objective of tax policy relating to the elderly.

Until 1984, Social Security and railroad retirement benefits, like veterans' pensions, were exempt from Federal taxation. That year, to help restore financial stability to Social Security, up to half of Social Security and railroad retirement Tier I benefits of higher income beneficiaries became taxable under a formula contained in the Social Security Act Amendments of 1983 (P.L. 98-21).

The Tax Reform Act of 1986 (P.L. 99-514), resulted in a number of changes to tax laws effecting older men and women. The Act repealed some longstanding tax advantages for elderly persons, while it increased personal exemptions and the standard deduction for the elderly. The impact at these changes will not be fully known until early in the next decade.

A. TAXES

1. BACKGROUND

A number of longstanding provisions in the tax code are of special significance to older men and women. These include the exclusion of Social Security and railroad retirement Tier I benefits for low- and moderate-income beneficiaries, a tax credit for the elderly, and the one-time exclusion of up to $125,000 in capital gains from the sale of a home for persons at least 55 years of age.

The Tax Reform Act of 1986 repealed or altered to less advantageous effect a number of tax provisions of importance to older persons. At the same time, other changes made by the Act, such as the increase the standard deduction provided for the elderly, may more than offset losses.

(A) TAXATION OF SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

For more than four decades following the establishment of Social Security, benefits were exempt from Federal income tax. The Congress did not explicitly exclude those benefits from taxation. Rather, their tax-free status arose from a series of rulings in 1938 and 1941 from what was then called the Bureau of Internal Revenue. These rulings were based on the determination that if Congress had intended to make Social Security benefits taxable, it would have provided the legislative authority to tax them when Social Security was created.

In 1983, the National Commission on Social Security Reform recommended that the Social Security benefits of higher income recipients be taxed, with the revenue put back into the Social Security trust funds. The proposal was part of a larger set of recommendations entailing financial concessions by employees, employers, and retirees alike to rescue Social Security from insolvency.

The Congress acted on this recommendation with the passage of the Social Security Act Amendments of 1983. As a result, up to one-half of the benefits of Social Security and railroad retirement recipients with incomes over $25,000 ($32,000 for joint filers) became subject to taxation. Since taxes already have been paid on the retired worker's share to the Social Security system, only the one half regarded as the employer's contribution (and on which income taxes have not previously been paid) is taxable. In the case of railroad retirement recipients, only the Social Security-equivalent portion (Tier I) is affected. In 1987, approximately 12 percent of Social Security beneficiaries were subject to this tax.

The limited application of the tax on Social Security benefits reflects the Congressional concern that lower- and moderate-income taxpayers not be subject to this tax. Because the tax thresholds are not indexed, however, with time, beneficiaries of more modest means will also be impacted.

The tax treatment of Social Security benefits is noteworthy for another reason. Under the 1983 formula, Social Security income became the only initially tax-exempt income which can be pulled (up to 50 percent) into taxable income status by the total of other taxable income and tax-exempt interest income.

Revenues from the taxation of Social Security benefits have continued to increase. In 1984, approximately $3 billion in taxes were paid into the Social Security trust funds. In 1985, that figure rose to $3.4 billion, and in 1986, to $3.7 billion.

In 1987, as a result of the lower tax rates provided under the Tax Reform Act of 1986, tax revenues from Social Security are expected to slip to $3.5 billion. But they are expected to resume their climb each year thereafter. In 1991, the last year for which projections are available, these tax revenues are expected to exceed $5 billion.

(B) ELDERLY TAX CREDIT

Officially named the Tax Credit for the Elderly and the Permanently and Totally Disabled, the elderly tax credit was enacted in 1954 with the codification of the Internal Revenue Code. Under this provision, qualifying retirees receive a tax credit equal to 15 percent of the first $5,000 (for single filers) and $7,500 (for joint filers) both of which are qualified individuals.

Congress established the credit to correct inequities in the taxation of different types of retirement income. Prior to 1954, retirement income generally was taxable, while Social Security and railroad retirement (Tier I) benefits were tax-free. To provide roughly similar treatment of these different types of retirement income, the new provision allowed retirees, 65 and older, a tax credit equal to 15 percent of the total of all retirement income.

In the Social Security Act Amendments of 1983, the Congress limited the credit to those 65 and older, or disabled. The Act also increased the initial amounts which qualify for the credit.

(C) ONE-TIME EXCLUSION OF CAPITAL GAINS ON THE SALE OF A HOME

The one-time home sale capital gains exclusion originated in the Internal Revenue Act of 1964. It was viewed as a way to protect homeowners from incurring tax liability on gains which were thought to result largely from inflation. In addition, proponents asserted that the Government should not tax away assets people had accumulated for retirement through home-ownership, nor discourage elderly persons from selling their homes to reduce expenses or to move to smaller quarters.

Originally, capital gains of $20,000 of the adjusted sales price of the house for persons 65 and older were excluded. Over the years, Congress raised the maximum excludable gain to $125,000 to reflect increases in average market prices for housing and lowered to 55 the age at which the exclusion can be taken.

(D) TAX REFORM ACT OF 1986

The Tax Reform Act of 1986 made such sweeping changes to the Internal Revenue Code that the Congress chose to issue the code as a completely new edition—something that has not occurred since 1954. As a result of the Act, the elderly were provided an increase in the amount of the standard deduction as well as other advantages available to the general population. Partially offsetting these benefits are the repeal of the extra personal exemption for the elderly (effective after 1987), the lowering in the medical deduction, and the end of the initial tax-free status of private pensions.

TABLE 1.—PERSONAL INCOME TAX RATES

1988		1989	
Taxable income	Tax rate (percent)	Taxable income	Tax rate (percent)
Married filing jointly:			
$0–$29,750	15	$0–$30,950	15
$29,750–$71,900	28	$30,950–$74,850	28
$71,900–$149,250 [1]	33		
Over $149,250	28		
Single:			
$0–$17,850	15	$0–$18,550	15
$17,850–$43,150	28	$18,550–$44,900	28
$43,150–$89,560 [1]	33	$44,900–$93,130	33
Over $89,560	28		

[1] The benefit of the 15 percent bracket is phased out when taxable income exceeds $43,150 (single) and $71,900 (joint). The top figure for the 33 percent bracket increased by $10,920 in 1988 for each exemption. For example, the 33 percent bracket for a family of 4 was $71,900 to $192,930.

(1) Extra Personal Exemption for the Elderly

The extra personal exemption for elderly persons was enacted in 1948 to provide some relief from the effects of the postwar economy on the elderly. At that time, this provision removed an estimated 1.4 million elderly taxpayers and others (blind persons also were provided the extra personal exemption) from the rolls, and reduced the tax burden for another 3.7 million. Effective in 1987, the exemption was no longer available.

(2) Deduction of Medical and Dental Expenses

Under prior law, medical and dental expenses, including insurance premiums, copayments, and other direct out-of-pocket costs, were deductible to the extent that they exceeded 5 percent of a taxpayer's adjusted gross income. The 1986 tax law raised the threshold to 7.5 percent.

Since the elderly require more health care per capita than the nonelderly, the cut in the medical deduction could have a disproportionately negative impact on some elderly persons. Although persons 65 and older constitute about 12 percent of the population, their health care expenditures account for about one-third of the national total. In 1984, the annual average per capita expenditure for the elderly was $4,200, compared with $1,200 for those under 65. However, it should also be noted that the availability of Medicare lessens, to some extent, the importance of the medical deduction to elderly persons.

(3) Private Pensions

Prior to 1986, retirees under the civil service retirement system or any other contributory pension plans generally had the benefit of the so-called 3-year rule. The effect of this rule was to exempt, up to a maximum of 3 years, pension payments from taxation until the amount of previously taxed employee contributions made during the working years was recouped. Once the employee's share was recouped, the entire pension became taxable.

Under the 1986 Act, the employer's contribution and previously untaxed investment earnings of the payment are calculated each month on the basis of the worker's life expectancy, and taxes are paid on the annual total of that portion. Retirees who live beyond their estimated lifetime then must begin paying taxes on the entire annuity, the rationale being that the retiree's contribution has been recouped and the remaining payments represent only the employer's contribution. For those who die before this point is reached, the law allows the last tax return filed on behalf of the deceased to treat the unrecouped portion of the pension as a deduction.

With a higher taxable income, some pensioners may be pushed into a higher tax bracket as a result of the provision. However, any initial tax increases are likely offset over the long run by the tax break on the retired worker's share of the pension during his or her estimated life time.

(4) Personal Exemptions and Standard Deductions

The new tax law provides for phased-in increases in the personal exemption. In 1988, the personal exemption was increased to $1,950, and for years 1989 and beyond, it will be increased to $2,000.

TABLE 2.—STANDARD DEDUCTIONS BY FILING STATUS

Filing status	Standard deduction	
	Under 65 and not blind	Age 65 or older or blind
1988:		
Single	$3,000	$3,750
Married filing jointly [1]	5,000	5,600
Married filing separately	2,500	3,100
Head of household	4,400	5,150
Qualifying widow(er)	5,000	5,600

[1] Use 2d column if either spouse is 65 or older or blind.

(5) Filing Requirements and Exemptions

An estimated 6 million additional taxpayers—many of them elderly—were exempted from filing income tax forms under the 1986 tax law. The law raised the levels below which persons are exempted from filing Federal income tax forms. Single persons 65 or older do not have to file a return if their income is below $5,650. For married couples filing jointly, the limit is $9,400 if one spouse is 65 or older or $10,000 if both spouses are 65 or older. Persons who are claimed as dependents on another individual's tax return do not have to file a tax return unless their unearned income exceeds $500 or their gross income exceeds their maximum allowable standard deduction ($3,100 for persons 65 or older or blind, $3,700 for persons who are both 65 or older and blind).

(6) Repeal of Other Provisions

A number of other provisions repealed by the 1986 Act also are of interest to elderly taxpayers. These include:

The dividend exclusion of up to $100 per taxpayer;

The 60 percent exclusion on capital gains (after 1986, capital gains will be treated as ordinary income);

The deductions for contributions to IRA's by taxpayers above certain income levels who participate in employer-provided pension arrangements;

The deduction for nonmortgage interest expense will be phased out through 1991;

The deduction for State and local sales tax (not a discretionary expenditure on necessities such as groceries, medicines, and prescription drugs); and

The income-averaging method of computing income tax.

2. ISSUES

(A) THE IMPACT OF TAX REFORM

The full impact of the tax reform measure will not be felt by many Americans until this year. Many provisions go into full effect this year.

One study prepared for the American Association of Retired Persons concludes that the 1986 tax reform measure ultimately will remove about 2 percent of the elderly from the tax rolls, and that tax payments for this age group as a whole will decline overall by about 1 percent. The study also concludes that on the whole the benefits of the new code to the elderly are substantially less than those to the nonelderly. Average tax savings are estimated at $18 and $401, respectively, for the two groups.

(B) SOCIAL SECURITY EARNING LIMITATIONS

Under current law, the working Social Security beneficiary loses $1 of benefits for every $2 earned over a specified limit. In 1988, the earnings limitation was $8,400 for the 65-69 age group (in 1990, the deduction will change to $1 for every $3 earned over the limit) and $6,120 for those under 65. For those over 69, there is no limit on earnings.

After the first year in which Social Security benefits are received, the earnings limitation is applied to total annual earnings, without regard to the number of months worked or the amount earned in any particular month. During the first year, the limits are applied on a monthly basis.

In 1988, bills were proposed to reduce or repeal the Social Security earnings limitation. Backers of this legislation have emphasized that the law discourages older men and women from working, and, when taken together with deductions, FICA and income taxes, the limitation can amount to a tax rate of 50 percent or higher. This poses particular hardships on older workers who cannot afford to retire and must continue working. In 1984, earnings accounted for one-quarter of the aggregate income of older taxpayers.

Additionally, opponents of the Social Security earnings limitation pointed out that the law discriminates against Social Security recipients with less benefits because they are subject to the same earnings ceiling as those receiving larger benefits.

On broader grounds, opponents contended that tax and public policies should encourage older men and women to continue working as long as they are willing and able. By eliminating the earnings limitation, more older men and women likely would continue contributing to the economic production of the Nation.

The principal obstacle facing such proposals is financial: Over a 5-year period, the cost of repealing the Social Security earnings limitation is estimated at $16 billion. In times of record Federal budget deficits, revenue losses of this magnitude pose larger economic implications. However, under a modified proposal (discussed in chapter 1), costs would be significantly less, thus increasing the chances of Congressional action.

(C) INCENTIVES FOR RURAL PRIMARY CARE

Despite increased numbers of physicians, it remains difficult to impossible to attract needed physicians to medically underserved and remote rural areas. Further exacerbating this problem is that up to 25 percent of rural physicians will retire or relocate within the next 5 years. Without a concerted effort of Federal and State governments, elderly persons living in rural areas will increasingly find it impossible to receive necessary health care.

In response, Senator David Pryor has introduced the Rural Primary Care Incentives Act of 1989, S. 1060. The legislation would provide primary care physicians who practice in federally designated high priority health manpower shortage areas a tax credit of $12,000 per year for 3 years based on a 5-year service incentive. Additionally, it would eliminate the taxable status of funds given to health personnel through the National Health Services Corporation Loan Repayment Program.

Presently, the bill is before the Senate Committee on Finance. It should receive serious consideration in the Senate during the 1990 session.

B. SAVINGS

1. Background

Since 1981 there has been considerable emphasis on increasing the amount of capital available for investment. By definition, increased investment must be accompanied by an increase in savings. Total national savings comes from three sources: Individuals saving their personal income, businesses retaining their profits, and the Government savings when tax revenues exceed expenditures. As part of the trend to increase investment generally, new or expanded incentives for personal savings and capital accumulation have been enacted in recent years.

At the same time, retirement income experts have suggested that incentives for personal savings be increased to encourage the accumulation of greater amounts of retirement income. Many retirees are dependent primarily on Social Security for their income. Thus, some analysts favor a better balance between Social Security, pensions and personal savings as sources of income for retirees. The growing financial crisis that faced Social Security in the early 1980's reinforced the sense that individuals should be encouraged to increase their preretirement savings efforts.

The life-cycle theory of savings has helped support the sense that personal savings is primarily saving for retirement. This theory postulates that individuals save little as young adults, increase their savings in middle age, then consume those savings in retirement. Survey data suggests that savings habits are largely dependent on available income versus current consumption needs, an equation that changes over the course of most individuals' lifetimes.

The consequences of the life-cycle savings theory raises questions for Federal savings policy. Tax incentives may have their greatest appeal to those already saving at above-average rates: Taxpayers who are reaching maturity, earning above-average incomes and subject to relatively high marginal tax rates. Whether this group presently is responding to these incentives by creating new savings or simply shifting after-tax savings into tax-deferred vehicles is a continuing subject for disagreement among policy analysts. For taxpayers who are young or have lower incomes, the tax incentives may be of little value. Expanding savings in this group necessitates a trade-off of increased savings for current consumption, a behavior which they are not under most circumstances inclined to pursue.

As a result, some observers have concluded that tax incentives will contribute little to the adequacy of retirement income for most individuals, especially those at the lower end of the income spectrum.

The dual interest in increased capital accumulation and improved retirement income adequacy has sparked an expansion of tax incentives for personal retirement savings over the last decade. However, in recent years, Congress has begun to question the importance and efficiency of expanded tax incentives for personal savings as a means to raise capital for national investment goals, and as a way to create significant net new retirement savings. These issues received attention in 1986 as part of the effort to improve the fairness, simplicity and efficiency of Federal tax incentives.

The role of savings in providing income in retirement has increased gradually over the last decade as new generations of older Americans with greater assets have reached retirement. In 1986, 26 percent of elderly income came from assets, compared with only 16 percent in 1962. Fully, 67 percent of the elderly had some income from assets in 1984, compared with 54 percent in 1962.

The distribution of asset income varies for different elderly subgroups. As 1986 figures indicates, the oldest old are less likely to have asset income than the younger elderly. Only 62 percent of those 80 and older had asset income in 1986, compared with 68 percent of those in the 65–69 age group. In 1986, 71 percent of elderly men had asset income, compared with 66 percent of elderly women. Whites are more than twice as likely to have asset income as other races; 71 percent of elderly whites had asset income, compared to only 30 percent for blacks and 31 percent of the elderly of Spanish origin.

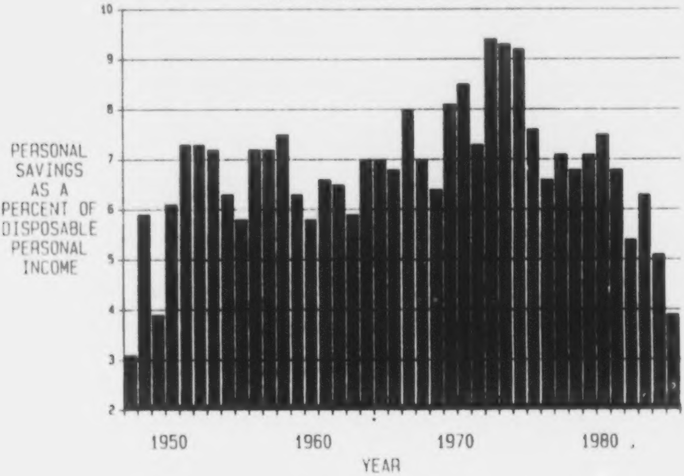
Finally, the likelihood of asset income receipt is directly proportional to total income. Asset income is much more prevalent among individuals with high levels of retirement income. Only 27 percent of elderly persons with incomes less than $5,000 receive income from assets, while 84 percent of those with incomes between $10,000 and $20,000 and 95 percent of those with income over $20,000 receive some asset income. One-third of the elderly with incomes greater than $20,000 relied on assets to provide more than half of their retirement income, while only 11 percent of those with income less than $5,000 relied on assets for more than half their retirement income.

Historically income from savings and other assets has furnished a small but growing portion of total retirement income. Assets remain a far more important source of income for the retired population on the whole than pension annuities, largely because less than one in three retirees receive pension benefits.

The effort to increase national investment springs from a perception that governmental, institutional and personal savings rates are lower than the level necessary to support a healthy economy. Except for a period during World War II when personal savings approached 25 percent of income, the personal savings rate in the United States has ranged between 5 percent and 8 percent of disposable income. (Chart 1 shows the variation in personal savings rates as a function of disposable personal income from 1947–87.) Many potential causes for these variations have been suggested, including demographic shifts in the age and composition or families and work forces and efforts to maintain levels of consumption in the face of inflation. Personal savings rates in the United States historically have been substantially lower than in other industrialized countries. In some cases it is only one-half to one-third of the savings rates in European countries.

CHART 1

PERSONAL SAVINGS RATE
UNITED STATES: 1947 - 1987



SOURCE: National Income Product Accounts. Bureau of Economic Analysis, Department of Commerce

For 1987, Commerce Department figures indicate that the personal savings rate was 3.8 percent, about the same as 1986. For the third and fourth quarters of 1987, the rates were 2.8 percent and 4.5 percent, respectively. Analysts suggest that without savings in corporate pensions, the country actually experienced a decline in savings overall. In part, this dramatically low figure may reflect an increase tendency to purchase goods on consumer credit. Given the additional expansion of tax incentives for retirement savings in recent years, the low rate of personal savings raises serious doubts about the effectiveness of those incentives. If retirement savings only take place in employer-sponsored plans, then policy analysts argue that retirement income goals might be better served by policies favoring these, rather than individual savings vehicles. I21Even assuming present tax policy creates new personal savings, critics suggest this may not guarantee an increase in total national savings available for investment. Federal budget surpluses constitute savings as well; the loss of Federal tax revenues resulting from the tax incentives may offset the new personal savings being generated. Under this analysis net national savings would be increased only when net new personal savings exceeded the Federal tax revenue foregone as a result of tax-favored treatment.

Recent studies of national retirement policy have recommended strengthening individual savings for retirement. Because historical rates of after-tax savings have been low, emphasis has frequently been placed on tax incentives to encourage savings in the form of voluntary tax-deferred capital accumulation mechanisms.

The final report of the President's Commission on Pension Policy issued in 1981 recommended several steps to improve the adequacy of retirement savings, including the creation of a refundable tax credit for employee contributions to pension plans and individual retirement savings. Similarly, the final report of the National Commission on Social Security recommended increased contribution limits for IRA's. In that same year, the Committee for Economic Development—an independent, nonprofit research and educational organization—issued a report which recommended a strategy to increase personal retirement savings that included tax-favored contributions by employees covered by pension plans to IRA's, Keogh plans, or the pension plan itself.

These recommendations reflected ongoing interest in increased savings opportunity. In each Congress since the passage of the Employee Retirement Income Security Act (ERISA) in 1974, there have been expansions in tax-preferred savings devices. This continued with the passage of the Economic Tax Recovery Act of 1981 (ERTA). From the perspective of retirement-specific savings, the most important provisions were those expanding the availability of IRA's, simplified employee pensions, Keogh accounts and employee stock ownership plans (ESOP's). ERTA was followed by additional expansion of Keogh accounts in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which sought to equalize the treatment of contributions to Keogh accounts with the treatment of contributions to employer-sponsored defined-contribution plans.

The evolution of Congress' attitude toward expanded use of tax incentives to achieve socially desirable goals holds important implications for tax-favored retirement savings. When there is increasing competition for Federal tax expenditures the continued existence of tax incentives depends in part on whether they can stand scrutiny on the basis of equity, efficiency in delivering retirement benefits, and their value to the investment market economy.

2. Issues

(A) INDIVIDUAL RETIREMENT ACCOUNTS (IRA'S)

(1) Pre-1986 Tax Reform

The extension of IRA's to pension-covered workers in 1981 by ERTA resulted in dramatically increased IRA contributions. In 1982, the first year under ERTA, IRS data showed 12.1 million IRA accounts, nearly four times the 1981 number. In 1983, the number of IRA's rose to 13.6 million, 15.2 million in 1984, and 16.2 million in 1985. In 1986, contributions to IRA's totalled $38.2 billion. The Congress anticipated IRA revenue losses under ERTA of $980 million for 1982 and $1.35 billion in 1983. However, according to Treasury Department estimates, revenue losses from IRA deductions for those years were $4.8 billion and $10 billion, respectively. By 1986, the estimated revenue loss had risen to $16.8 billion. Clearly, the program had become much larger than Congress anticipated.

The rapid growth of IRA's posed a dilemma for employers as well as Federal retirement income policy. The increasingly important role of IRA's in the retirement planning of employees began to diminish the importance of the pension bond which links the interests of employers and employees. Employers began to face new problems in attempting to provide retirement benefits to their work forces.

A number of questions arose over the efficiency of the IRA tax benefit in stimulating new retirement savings. First, does the tax incentive really attract savings from individuals who would be unlikely to save for retirement otherwise? Second, does the IRA tax incentive encourage additional savings or does it merely redirect existing savings to a tax-favored account? Third, are IRA's retirement savings or are they tax-favored savings accounts used for other purposes before retirement?

Evidence indicated that those who used the IRA the most might otherwise be expected to save without a tax benefit. Low-wage earners barely used IRA's. The participation rate among those with less than $20,000 income was two-fifths that of middle-income taxpayers ($20,000-$50,000 annual income) and one-fifth that of higher-income taxpayers ($50,000 or more annual income). Also, younger wage earners, as a group, were not spurred by the IRA tax incentive. As the life-cycle savings hypothesis suggests, employees nearing normal retirement age are three times more likely to contribute to an IRA than workers in their twenties. Those without other retirement benefits also appear to be less likely to use an IRA. Employees with job tenures greater than 5 years display a higher propensity toward IRA participation at all income levels. For those not covered by employer pensions, utilization generally increases with age, but is lower across all income groups than for those who are covered by employer pensions. In fact, 46 percent of IRA accounts are held by individuals with vested pension rights.

Though a low proportion of low-income taxpayers utilize IRA's relative to higher income counterparts, those low-income individuals who do contribute to an IRA are more likely than their high-income counterparts to make the contributions from salary rather than pre-existing savings. High-income taxpayers apparently are more often motivated to contribute to IRA's by a desire to reduce their tax liability than to save for retirement.

One of the stated objectives in the creation of IRA's was to provide a tax incentive for increased savings among those in greatest need. This need appears to be most pressing among those with low pension coverage and benefit receipt resulting from employment instability or low average career compensation. However, the likelihood that a taxpayer will establish an IRA increases with job and income stability. Thus, the tax incentive appears to be most attractive to taxpayers with relatively less need of a savings incentive. As a matter of tax policy, IRA's could be an inefficient way of improving the retirement income of low-income taxpayers.

An additional issue was whether all IRA savings are in fact retirement savings or whether IRA's were an opportunity for abuse as a tax shelter. Most IRA savers probably view their account as retirement savings and are inhibited from tapping the money by the early 10-percent penalty on withdrawals before age 59½. However, those who do not intend to use the IRA to save for retirement, can still receive tax benefits from an IRA even with early withdrawals. Most analysts agree that the additional buildup of earnings in the IRA, that occurs because the earnings are not taxed will surpass the value of the 10-percent penalty after only a few years, depending upon the interest earned. Some advertising for IRA savings emphasized the weakness of the penalty and promoted IRA's as short-term shelters. Although the tax advantage of an IRA is greatest for those who can defer their savings until retirement, they are not limited to savings deferred for retirement.

An additional concern is that the IRA was not equally available to all taxpayers who might want to save for retirement. Nonworking spouses of workers saving in an IRA could contribute only an additional $250 a year. Some contended that this created an inequity between two-earner couples who could contribute $4,000 a year and one-earner couples who could contribute only $2,250 in the aggregate. They argued that it arbitrarily reduces the retirement income of spouses, primarily women, who spend part or all of their time out of the paid work force. Those who opposed liberalization of the contribution rules contended that any increase would primarily advantage middle- and upper-income taxpayers, since the small percentage of low-income taxpayers who utilized IRA's often did not contribute the full $2,000 permitted them each year.

(2) Post-1986 Tax Reform

The IRA provisions of the 1986 Tax Reform Act were among the most significant changes affecting individual savings for retirement. To focus the deduction more effectively on those who need it, the Act repealed the deductibility of IRA contributions for pension plan participants and their spouses, with an adjusted gross income (AGI) in excess of $35,000 (individual) or $50,000 (family). For pension-covered workers and their spouses with AGI's between $25,000 and $35,000 (individual) or $40,000 and $50,000 (family) the maximum deductible IRA contribution is reduced in relation to their incomes. Workers in families without pensions, and pension-covered workers with AGI's below $25,000 (individual) and $40,000 (family) retain the $2,000 per year IRA contribution. Even with the loss of the IRA deduction for some workers, however, all IRA accounts, even those receiving only after-tax contributions, continue to accumulate earnings tax free.

(B) EMPLOYEE STOCK OWNERSHIP PLANS (ESOP'S)

(1) Pre-1986 Tax Reform

Employee stock ownership plans were promoted as a means for transferring the ownership of a company's capital to its workers. Although ESOP's can become a valuable source of retirement income to supplement Social Security, pension benefits and personal savings, they are not designed (or intended) to be an employee's sole or primary retirement savings vehicle, or a replacement for a traditional pension arrangement. Such a plan can offer an employee a potential investment return exceeding that of a standard pension plan if the company is growing at a substantial rate or is consistently profitable.

However, under an ESOP, an employee not only bears the risk of the plan's investment performance, but also the additional risk of relying on a nondiviersified investment portfolio. As the value of a company's shares can fluctuate over a wide range in response to the employer's fortunes, an ESOP cannot be considered a secure primary retirement vehicle for participants. In recent years, there was considerable concern when some corporations terminated their defined benefit pension plans and replaced them with ESOP's.

The most sensitive issue surrounding employee stock ownership plans was their expanding use in closely held corporations, where the value of the stock to employees is uncertain. For employees to have meaningful ownership interest in their employer through participation in an ESOP, the stock must be fairly valued and the employees must have some control over the way in which the stock is voted. But in a privately held corporation, one or both of these elements may be missing or constrained. It is difficult to value ESOP-contributed stock of a privately owned corporation because there is no ready market for its resale. This creates an enormous potential for abuse. By overvaluing stock contributions an employer-owner can inflate the tax benefit received while employees may be hurt because the real value of the stock is less than its nominal worth.

Although Congress clearly had expressed its intent to encourage employee stock ownership, the effectiveness of the ownership and productivity incentives, which form the basis of congressional policy, became debatable. In the case of ESOP's in closely held corporations with limited voting rights passthrough, the absence of voting rights and of a ready market for resale, cast doubt on the existence of any realistic incentive at all. Even in publicly traded corporations with full passthrough voting, some employee organizations have argued that stock in the ESOP does not accumulate fast enough compared to the total amount of stock outstanding to give employees any significant voice in corporate decisionmaking. As a result, several employee organizations opposed the implementation of ESOP's unless coupled with representation on the employer's board of directors.

The ESOP concept had been supported by Congress in spite of these unresolved issues. It is important to note, however, that since an ESOP's value is inextricably tied to the financial health of the employer, their implementation should be traded off against current wages rather than retirement benefits when being used to save financially distressed employers. If an ESOP is used to replace pension benefits, the demise of the employer could wipe out a substantial portion of an employee's retirement income as well. However, by exchanging the ESOP for current wages, an employee's retirement benefit remains insulated to some degree from the consequences of the employer's potential demise, while a much stronger link is forged between productivity incentives and the employee's present compensation.

(2) Post-1986 Tax Reform

The Tax Reform Act of 1986 significantly affected ESOP's, both in their taxation and the manner in which they may be managed. Generally, the new rules were aimed at increasing the attractiveness of ESOP's and the protections available to participating workers.

To reduce the risk associated with ESOP's the Act requires that partial diversification of a plan for workers nearing retirement be allowed. As result, a worker at 55 with at least 10 years of service may diversify up to 25 percent of his or her account. At age 60, the amount that which can be reinvested in other securities increases to 50 percent. At least three investment options must be provided.

In addition, the Act shortened the period within which distributions to participants must be made. Under current law, unless the retired worker elects otherwise, distributions must begin no later than 1 year after retirement, disability, or death.

The 1986 law also established a number of tax incentives, including an estate tax deduction of 50 percent of the proceeds from a sale of an ESOP's assets. The deduction is effective for estate sales through 1991.

(C) RESIDENTIAL RETIREMENT ASSETS

(1) Pre-1986 Tax Reform

Tax incentives, which long have promoted the goal of home ownership, include the income tax deductions for real estate taxes and home mortgage interest. As in the one-time exclusion of capital gains on the sale of a home these tax breaks recognize that for many elderly persons a home may represent their principal or only retirement asset.

(2) Post-1986 Tax Reform

Prior to the 1986 Tax Reform Act, all real estate mortgage interest was tax deductible. To generate new Federal revenues, the Act limited the deduction to interest on home mortgages or home equity loans taken out on a principal residence or a second home to purchase a home, make home improvements, or pay medical or educational expenses. Thus, interest paid on any part of the loan used for other purposes no longer qualifies for the deduction. (The deduction for real estate taxes remains unchanged.)

The home mortgage interest deduction was further restricted under the Omnibus Budget Reconciliation Act of 1986 (P.L. 100-203). The Act placed a ceiling on the amount of a mortgage that qualifies for the tax deduction. For loans used to acquire or improve a principal or second residence, the limit is $1 million. For home loans used for other debt purposes (limitation to medical or educational debts eliminated), the cap is $100,000.

C. PROGNOSIS

In coming years, the full impact of the 1986 Tax Reform Act will unfold. On the one hand, the elimination of the additional tax exemption for the elderly and the lowering of the medical deduction will be sources of concern for some elderly taxpayers. On the other, increases in the personal exemption and the additional increase in the standard deduction will provide clear tax advantages.

Most likely, the new rules will have a mixed effect on the elderly. Some many be dropped from the tax rolls, while others may pay additional taxes. Some may pay reduced taxes, while others may pay the same as before. The extent to which the considerable benefits under the 1986 Act fail to offset potential losses from less advantageous changes, certain tax provisions may be a source of controversy. However, the massiveness of the tax overhaul make unlikely any significant tax or savings incentive legislation in 1989 or soon thereafter.

As in the past, the Federal tax and savings policy will continue to take into account the vulnerable financial status of many older Americans in their post-working years. At the same time, broader financial concerns, particularly the need to reduce the Federal budget deficit, can be expected to play an increasing role in future debates in this area.

Chapter 4

EMPLOYMENT

OVERVIEW

Concurrent with the rapid aging of the U.S. population has been a dramatic lengthening of the time older Americans spend in retirement. Not only are people living longer, but many are choosing to retire at a much earlier age. In fact, early retirement is a concept which is fast becoming a part of the American way of life. At the same time, however, many persons desire or need to continue working in their later years. For them, age discrimination often remains an obstacle.

Age, like race, sex, religion, and national origin, is a protected category under Federal law. Eliminating age bias in the workplace is consistent with the tradition in America of barring arbitrary policies which discriminate against individuals on the basis of their beliefs or their personal characteristics. The nearly unanimous opposition to mandatory retirement policies by the American public shows the strong sentiment against arbitrary age bias in employment. Nevertheless, statutory protections against age discrimination remain incomplete and somewhat ineffectual.

While the unemployment rate for older persons is approximately half of that for younger persons, once an older worker loses a job, his or her duration of unemployment tends to be much longer. A 1988 report by the Congressional Research Service, U.S. Library of Congress, entitled "A Demographic Portrait of Older Workers," shows that in the year 1987 workers aged 55 to 64 years were out of work for an average of 22 weeks, and workers 65 and over were unemployed for an average of 17.8 weeks. The average of unemployment for all workers aged 16 and over was 14.5 weeks.

A. BACKGROUND

1. Age Discrimination

Numerous obstacles to older worker employment persist in the workplace, including negative stereotypes about aging and productivity; job demands and schedule constraints that are incompatible with the skills and needs of older workers; and management policies which make it difficult to remain in the labor force, such as early retirement incentives. For the most part, these obstacles have their roots in age discrimination.

Age discrimination in the workplace plays a pernicious role in blocking employment opportunities for older persons. The development of retirement as a social pattern has helped to legitimize this form of employment discrimination. Indeed, retirement is a concept which has become imbedded in the American conciousness.

Although there is no agreement on the extent of age-based discrimination, nor how to remedy it, few would argue that the problem exists for millions of older Americans. Despite Federal laws banning most forms of age discrimination from the workplace, most Americans view age discrimination as a serious problem. Two nationwide surveys by Louis Harris and Associates, one in 1975 followed by another in 1981, found nearly identical results: 8 out of 10 Americans believe that "most employers discriminate against older people and make it difficult for them to find work."

The perception of widespread age discrimination held by the public also is shared by a majority of business leaders. According to a 1981 nationwide survey of 552 employers conducted by William M. Mercer, Inc., 61 percent of employers believe older workers are discriminated against on the basis of age; 22 percent claim it is unlikely that, without the present legal constraints, a company would hire someone over age 50 for a position other than senior management; 20 percent admit that older workers (other than senior executives) have less of an opportunity for promotions or training; and, 12 percent admit that older workers' pay raises are not as large as those of younger workers in the same category.

The pervasive belief that all abilities decline with age has fostered the myth that older workers are less efficient than younger workers. The forms of age discrimination range from the more obvious forced retirement, to more subtle job harassment and early retirement incentives. Part of this problem is that younger workers, rather than older workers, receive the skills and training needed to keep up with technological changes. Too often, employers wrongly assume that it is not financially advantageous to retrain an older worker. They believe that a younger employee will remain on the job longer, simply because of his or her age. In fact, the mobility of today's work force does little to guarantee greater longevity on the part of a younger worker. According to the Bureau of Labor Statistics, the median job tenure for a current employee is as little as 4.2 years.

Another discriminatory practice involves the proposed relocation of an older employee to an undesirable area in the hopes that the employee will instead decide to resign. In a related effort, an employer may begin to give an older employee poor evaluations to build a record for justifying the employee's later dismissal.

Without question, age-based discrimination in the workplace poses a serious threat to the welfare of many older persons. While the number of older persons receiving maximum Social Security benefits is increasing, most retirees get less than the maximum. According to the 1989 edition of the U.S. Senate Special Committee on Aging's report entitled "Aging America: Trends and Projections" in 1988, 73 percent of persons aged 65 or older had a total annual monetary income of less than $15,000. Other reports reveal that only slightly more than half of the work force is covered by a private pension plan, and most older persons do not have substantial holdings in savings, stocks, insurance policies, or bonds.

According to the National Commission for Employment Policy, in 1980 several million older workers suffered severe labor market problems, including unemployment or underemployment. CRS's "A Demographic Portrait of Older Workers" reports that in 1987 the unemployment rate was 3.5 percent for workers aged 55 to 64, 2.6 percent for workers aged 65 to 69, and 2.4 percent for workers aged 70 and over. Although older workers as a group have the lowest unemployment rate, these numbers do not reflect those older individuals who have withdrawn completely from the labor force due to frustration with labor market problems. Duration of unemployment is significantly longer among older workers, and many report that they want a job but are not looking because they believe that they cannot find one.

According to the Bureau of Labor Statistics (BLS), because older job seekers are more likely to be unemployed for a longer period than younger persons, they are more likely to exhaust available unemployment insurance benefits and suffer economic hardships. The 1978 Employment and Training Report of the President indicates that the problems of older unemployed workers are worsened by the fact that many persons over 45 still have significant financial obligations.

Not surprisingly, evidence suggests that there is a link between the longer duration of unemployment for older workers and the higher rate of discouraged workers in this age group. For men age 65 and over, the annual average level of discouraged workers is almost as large as the number of unemployed. The BLS reports that the prospects of an older male worker finding work are so low that he is three times more likely to become discouraged than his younger counterpart. Further, when older workers are fortunate enough to find work, they generally face a cut in earnings and experience a diminished status compared to their previous employment.

Psychologists report that discouraged workers can face wrenching psychological stress, including hopelessness, depression, and frustration. In addition, medical evidence suggests that forced retirement can adversely affect a person's physical, emotional, and psychological health even to the point where a life span may be shortened. According to the American Association of Retired Persons (AARP), 30 percent of the Nation's retirees are believed to suffer from serious adjustment problems.

Although the attitude persists that older workers hinder management efforts to improve productivity, there nevertheless is a growing recognition of their value. A 1985 study by Waldman and Avolio revealed little evidence for the "somewhat widespread belief that job performance declines with age." Among their findings was a strong correlation between performance improvements and increasing age, especially in objective measures of productivity. They concluded that "although chronological age may be a convenient means for estimating performance potential, it falls short in accounting for the wide range of individual differences in job performance for people at various ages."

Many employers have reported that older workers stay on the job longer than younger workers. Notwithstanding a widespread bias against age, some employers view older workers as offering experience, reliability, and loyalty. As supporting evidence, a 1985 AARP survey of 400 businesses reported that older workers generally are regarded very positively and are valued for their experience, knowledge, work habits, and attitudes. In the survey, employers give older workers their highest marks for productivity, attendance, commitment to quality, and work performance. As many as 90 percent stated that older workers are cost-effective, while a majority reported that the cost of older workers was justified.

Gradually, discriminatory attitudes toward older workers are changing, but much more must be done to ensure employment opportunities for older workers. At present, it is clear that age discrimination is reducing the work efforts of older persons, encouraging premature labor force withdrawal, and increasing the draw on Social Security and private pensions. Without effective solutions to age discrimination in the workplace, these problems promise to persist.

(A) THE AGE DISCRIMINATION IN EMPLOYMENT ACT

Over two decades ago, the Congress enacted the Age Discrimination in Employment Act of 1967 (ADEA), "to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and workers find ways of meeting problems arising from the impact of age on employment." The ADEA was signed into law as Public Law 90-202.

In large part, the ADEA arose from a 1964 Executive order issued by President Johnson declaring a public policy against age discrimination in employment. Three years later, the President called for Congressional action to eliminate age discrimination. Nevertheless, the ADEA was the culmination of extended debate concerning the problems of providing equal opportunity for older workers in employment. At issue was the need to balance the right of the older worker to be free from age discrimination in employment with the employer's prerogative to control managerial decisions. The provisions of the ADEA attempt to balance these competing interests by prohibiting age discrimination based upon an employer's arbitrary policies which would prevent employment of individuals above a certain age. The law provides that arbitrary age limits may not be used as conclusive determinations of nonemployability, and that employment decisions regarding older persons should be based on an individual assessment of each applicant's or employee's potential or ability.

As originally enacted, the ADEA prohibited employment discrimination against persons aged 40 to 65. As a result of amendments to the law in 1986, however, there currently is no upperlimit cap on these protections in all but a select few professions. The ADEA virtually covers all employees 40 years of age or older.

Under the ADEA, actions otherwise deemed unlawful may be permitted only if they are based upon the following considerations: (1) Where age is a bona fide occupational qualification reasonably necessary to normal operations of a particular business; (2) where differentiation is based on reasonable factors other than age (e.g., the use of physical examinations relating to minimum standards reasonably necessary for specific work to be performed on a job); (3) to observe the terms of a bona fide seniority system or a bona fide employee benefit plan such as a retirement, pension, or insurance plan, with the qualification that no seniority system or benefit plan may require or permit the involuntary retirement of any individual who is covered by the ADEA; and (4) where an employee is discharged for good cause. Also, an executive or high-ranking, policymaking employee in the private sector entitled to annual private retirement benefits of at least $44,000 could be compulsorily retired at age 65, simply because of age. This is known as the executive exemption, and it was designed to allow turnover at the top levels of the organization. While the exemption has strong support among business leaders, recent evidence shows that it is used only infrequently by a small number of employers.

Since it's enactment in 1967, the ADEA has been amended a number of times. The first set of amendments occurred in 1974, when the provisions of the law were extended to include Federal, State, and local government employers. The number of workers covered also was increased by limiting exemptions to employers with fewer than 20 employees. (Previous law exempted employers with 25 or fewer employees.) In 1978, the ADEA was amended to extend protections to age 70 for private sector, State, and local government employers, and by removing the upper age limit for employees of the Federal Government.

In 1982, the ADEA was amended by the Tax Equity and Fiscal Responsibility Act (TEFRA) to include the so-called "working aged" clause. As a result, employers are required to retain their over-65 workers on the company health plan rather than automatically shifting them to Medicare. Under previous law, Medicare was the primary payer and private plans were secondary. TEFRA reversed the situation, making Medicare the payer of last resort. While this provision was designed to be a cost-saver for Medicare, it poses an obstacle to employment for older workers because it increases the costs of their employment.

Amendments to the ADEA were also contained in the 1984 reauthorization of the Older Americans Act, Public Law 98–459. Under the 1984 amendments, the ADEA was extended to U.S. citizens who are employed by U.S. employers in a foreign country. Support for this legislation stemmed from the belief that many such workers should not be subject to possible age discrimination just because they are assigned abroad. Also, the executive exemption was raised from $27,000 to $44,000, representing the annual private retirement benefit level for determination of exemption from the ADEA for persons in bona fide executive or high policymaking positions.

Effective January 1987, mandatory retirement was eliminated altogether by the Age Discrimination in Employment Amendments of 1986. By removing the upper age limit, Congress sought to protect workers age 40 and above against discrimination in all types of employment actions, including forced retirement, hiring, promotions, and terms and conditions of employment.

Currently, there are approximately 3 million Americans age 65 and over in the work force. Many of them continue working for reasons of self-fulfillment, but more often it is out of economic necessity. The 1986 Amendments to the ADEA also extended through the end of 1993 and exemption from the law for institutions of higher education and for State and local public safety officers.

(B) THE EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

The Equal Employment Opportunity Commission (EEOC) is responsible for enforcing laws prohibiting discrimination. These include: (1) Title VII of the Civil Rights Act of 1964; (2) The Age Discrimination in Employment Act of 1967; (3) The Equal Pay Act of 1963; and (4) Sections 501 and 505 of the Rehabilitation Act of 1973.

When originally enacted, enforcement responsibility for the ADEA was placed with the Department of Labor (DOL) and the Civil Service Commission. In 1979, however, the Congress enacted President Carter's Reorganization Plan No. 1, which called for the transfer of responsibilities for ADEA administration and enforcement to the EEOC effective July 1, 1979.

Since taking over responsibility for the ADEA, the EEOC has alternatively been praised and criticized for its enforcement performance of the ADEA. In recent years, concerns have been raised over EEOC's decision to move away from broad complaints against large companies and entire industries to more narrowly focused cases involving few individuals. Critics also point to the large gap between the number of age-based complaints filed—during fiscal year 1988, the EEOC received 11,454 ADEA complaints—and the EEOC's modest litigation record. In fiscal year 1988, the EEOC filed 106 suits on behalf of complainants.

2. FEDERAL PROGRAMS

The Federal Government provides funds for training disadvantaged and dislocated workers to assist them in becoming more employable. Two important Federal programs designed to promote the employment opportunities of older workers are the Job Training Partnership Act Program and the Senior Community Service Employment Program under Title V of the Older Americans Act.

(A) THE JOB TRAINING PARTNERSHIP ACT

The Job Training Partnership Act (JTPA), enacted in 1982, established a nationwide system of job training programs administered jointly by local governments and private sector planning agencies. For the program year from July 1, 1989, through June 30, 1990, $3.73 billion was authorized in appropriations. This compares to the $3.75 billion appropriated for JTPA in fiscal year 1988.

JTPA establishes two major training programs: Title II for economically disadvantaged youth and adults, with no upper age limit; and Title III for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to reemployment. Under the Title II-A program, which authorizes training for disadvantaged youth and adults, funds are allotted among States according to the following three equally weighted factors: (1) Number of unemployed individuals living in areas with jobless rates of at least 6.5 percent for the previous year; (2) number of unemployed individuals in excess of 4.5 percent of the State's civilian labor force; and (3) the number of economically disadvantaged individuals. Training under Title II-A can include on-job training, classroom training, remedial education, employability development, and a limited amount of work experience. For the period July 1, 1987 through June 30, 1988, 31,864 persons 55 and older participated in the Title II-A program, representing 4 percent of total adult participants.

Section 124(a-d) of JTPA also establishes a statewide program of job training and placement for economically disadvantaged workers age 55 or older. Governors are required to set aside 3 percent of their Title II-A allotments for this older workers program. The older workers program under section 124 of JTPA is meant to be operated in conjunction with public agencies, private nonprofit organizations and private industries. Programs must be designed to assure the training and placement of older workers in jobs with private business concerns. During program year 1987, 41,927 persons 55 and older were served under this program.

For workers who have been or are about to be laid off, are eligible for or have exhausted their entitlement to unemployment compensation, and are likely to return to their previous occupation or industry, Congress created Title III. The dislocated workers program is administered by the States and includes such services as job search assistance, job development, training in job skills for which demand exceeds supply, relocation assistance and activities conducted with employers or labor unions to provide early intervention in case of a plant closing. During the period between July 1, 1987 and June 30, 1988, approximately 7,856 persons 55 and over were served by the Title III program (about 8 percent of total program participants).

As a result of enactment of the Worker Adjustment and Retraining Act of 1988, Public Law 100-379, the Title III program was significantly restructured and further funding was authorized. Under previous law, Title III had been similar to a block grant program, with few specific Federal standards imposed. However, the new law required that States establish a number of specific subgroups to carry out the program and placed a stronger emphasis on job training. The new program was scheduled to begin in July 1989.

According to 1987 findings of the National Commission for Employment Policy (NCEP), the JTPA is working well and, with minor exceptions, is meeting its legislative mandate. The report did acknowledge that conversations with State Job Training Coordination Council chairs confirmed that some States are having difficulty using the 3 percent set-aside funds for older workers due to recruitment problems and difficulty in placing this population.

The need for services provided under JTPA is underscored by a 1988 DOL study of displaced workers. According to the study, 4.7 million workers lost their jobs due to the decline of an industry or a plant closing between 1983 and 1988. The chance of reemployment for these displaced workers declined significantly with age. Only 51 percent of those between 55 and 64 were able to reenter the labor force in any capacity (as compared to 71 percent for those between the ages of 20 and 24). Only 30 percent of those over 65 became reemployed. Of those who found a job, more than half (55 percent) received lower pay than at their previous position and more than one-third took salary cuts of more than 20 percent. The study showed that the older an individual was when he or she lost a job, the longer he or she would be unemployed and the more likely he or she would become completely discouraged and drop out of the labor force altogether. Overall, there are more than 800,000 "discouraged" workers in the Nation.

(B) TITLE V OF THE OLDER AMERICANS ACT

The Senior Community Service Employment Program (SCSEP) was given statutory life under Title IX of the Older Americans Comprehensive Services Amendments of 1973. The program's stated purpose is "to promote useful part-time opportunities in community service activities for unemployed low-income persons." SCSEP responds to certain identified needs of older persons by providing opportunities for part-time employment and income. It also serves as a source of labor for various community service activities and can assist unemployed older persons in moving into permanent unsubsidized employment. Amendments passed in 1978 redesignated the program as Title V of the Older Americans Act and it was reauthorized through fiscal year 1987 by Public Law 98-459, the Older Americans Act Amendments of 1984. The act was again reauthorized by the Congress in 1987.

The program is administered by the Department of Labor, which awards funds to national sponsoring organizations and to State agencies. Persons eligible under the program are those who are 55 years of age and older (with priority given to persons 60 years and older), who are unemployed, and whose income level is not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services. Enrollees are paid the lessor of the Federal or State minimum wage or the local prevailing rate of pay for similar employment. Federal funds may be used to compensate participants for up to 1,300 hours per year, including orientation and training. Participants work an average of 20-25 hours per week. In addition to wages, enrollees receive physical examinations, personal and job-related counseling and, under certain circumstances, transportation for employment purposes. Participants may also receive training, which is usually on-the-job training and oriented toward teaching and upgrading job skills.

The SCSEP is one of the few remaining direct job creation programs since the elimination of the Comprehensive Employment and Training Act and Public Service Employment programs. Nearly half of the enrollees are between the ages of 55 and 64, and more than a quarter are 70 or older. About 70 percent are females, half of whom have not completed high school, and approximately 80 percent have a family income below the poverty line.

The SCSEP has been steady increases in funding and participant enrollment since its inception. In the 1968-69 program year, the first full year of its operation in a form similar to the current program, participant enrollment was 2,400 with a budget of $5.5 million. In program year July 1, 1989 to June 30, 1990, Title V funding appropriations are $343.8 million. This includes $268 million for national contracts and $75.6 million for State grants. The fiscal year 1989 appropriation represents a funding increase over fiscal year 1988, resulting in an increase in employment positions supported by the program from 64,813 to 65,798.

In recent years, the program has received generally positive reviews. In fiscal year 1986, a number of reports were issued that confirmed the general view that the program was successful and provided useful suggestions for improvements.

B. ISSUES AND RESPONSES

1. Our Aging Work Force

(A) DEPARTMENT OF LABOR STUDIES

In January 1989, the Department of Labor released two new reports on older workers and their impact on our Nation's labor market. These reports analize current work force and labor market data, and make important and interesting projections for older workers for the future.

(1) Demographic Trends in the Work Force

Demographic trends in the work force are examined in a DOL report entitled "Older Worker Taskforce: Key Policy Issues for the Future." The report projects that by the year 2000 the media age of the labor force will increase from about 36 to 39. Also, by the year 2000 the report projects an increase in the number of workers aged 55 and over and a decrease of almost 1 million in the number of workers aged 16 to 24. These figures confirm that with the aging of the "baby boomers," the population from which our work force is drawn is also aging.

When these projections are combined with the report's additional projection that labor force participation among individuals 55 years of age and older will decrease significantly by the year 2000, the result is a potential labor shortage. The report concludes that it is important for the government and employers to remove institutional barriers which discourage older workers from continuing in our re-entering the work force. In addition, incentives to retain or attract older workers should be emphasized, and training should be provided to older workers as a means for enhancing and upgrading their skills.

(2) Barriers and Disincentives for Older Workers

As discussed above, there has been a decreasing trend in work force participation by older workers. The average age at which people begin to draw Social Security benefits is now 63. However, there is growing concern in some circles about the consequences of early retirement. Many contend that a large number of employees who leave the work force, either voluntarily or due to forced retirement, find themselves ill-prepared for the financial consequences. While many believe that retirees who left the work force at too early an age are attempting to return, there is presently little proof.

The 1987 unemployment rates for workers in the age groups of 45 to 54, 55 to 64, and 65 and older were significantly lower than the unemployment rates for younger workers. Since an individual must be out of work and actively seeking employment in order to be counted as unemployed, there are at least two viable explanations for these differences. One explanation is encouraging and the other is not. First, the improved pension system may be making it possible for more workers to leave the labor force and permanently retire. Second, the frustration of older individuals in enduring much longer periods of unemployment than younger individuals may be forcing many of them to give up and leave the labor force.

Legislation was enacted on December 22, 1987, as Public Law 100-202 to require a study of older persons who are attempting to re-enter the work force. The purpose of the study was to provide the Congress with a better understanding of the issues and obstacles facing older persons seeking to re-enter the workplace.

The DOL report on this study is entitled "Labor Market Problems of Older Workers." The report reiterates long-standing problems facing older persons seeking employment, concluding that many older workers are pressured into early retirement and that "pension rules and job market realities severely limit their options and opportunities." The report also points out that a number of financial disincentives to re-entering the job market persist, including the low pay of part-time work and the Social Security earnings limitation. Looking ahead, the report states that the average retirement age, which had been on a downward trend, has stabilized or gone up slightly in recent years, and that there may be an increased demand for older workers as the general population continues to age. Ultimately, however, the report concludes that the state of the Nation's economy will determine the value accorded to older workers.

(B) HEALTH COSTS

While we have witnessed a steady decline in labor force participation by older people over the past several decades, concerted efforts are now being directed toward reversing this trend. "Worklife extension" is the term used to describe the move to extend the worklife of older persons willing and able to work. An important theme in the discussion of worklife extension is the heatlh of the older population. Employers and policymakers are concerned about the health implications of extended worklife, especially as they relate to issues of labor supply, productivity, employees health costs, and health maintenance.

A February 1985 information paper entitled "Health and Extended Worklife," prepared for use by the Special Committee on Aging, presents information about the health status of older persons as it may relate to extended work lives. The findings of the study indicate that the noninstitutionalized older population, and particularly the younger members of that population, are healthier than is widely believed. Health is one of several variables which affect the supply of workers, their level of productivity, and their utilization of health services, and the data presented in this paper can be of assistance to the Congress and employers in making informed decisions about employment and retirement issues.

Conventional wisdom suggests that older workers are paid more than younger workers for the same job and that, therefore, older workers are more expensive. This rationale has frequently been used to support early retirement programs on the assumption that younger workers can be hired at lower cost to replace older workers. There is, unfortunately, a dearth of empirical information to help discern whether it costs more to employ older workers than younger workers. In September 1984, the Senate Aging Committee released an information paper which examines factors related to patterns of labor costs by age, and discusses direct compensation, employee benefits, turnover, training, performance, and productivity.

The evidence indicates that there are some types of employment costs which vary by age, and that overall compensation costs increase by age, largely because of increasing employee benefit costs. There is, however, no statistical evidence that direct salary costs on an economywide basis increase by age. Employee benefits costs are not usually separated by age, and individual employers do not generally make hiring and retention decisions on the basis of benefit costs. General increases in medical care costs, combined with an expanding set of laws and regulations, have served, however, to focus the spotlight on employee benefit costs for older workers, and it is possible that employers will give more consideration to this issue in the future.

The belief that older workers cost more seems generally related to feelings about performane and productivity. There is no statistical evidence to indicate generally poorer performance or productivity by age, and the limited data available refutes the basic notion that older workers are less capable. However, there is a significant issue relating to maintenance of skills and training. Over time, as the nature of work changes and the skills of the employee are not kept up to date, there will be an increasing mismatch of skills to the job, leading to deterioration of performance on that specific job. If older workers are to be cost-effective, their skills must be continuously updated through training and education to assure continued productivity. The two major conclusions of the information paper are as follows:

—It is extremely important to encourage the maintenance of skills and lifelong education to prevent older worker obsolescence and to provide individuals with the skills to compete on a fair basis for jobs within or outside of their companies. Up-to-date skills are more important than any age-related capabilities in human resource cost and older worker productivity.

—Legislative and regulatory requirements affecting employment costs for older workers should not place undue cost or administrative problems on employers. Such requirements can discourage the employment of older workers.

A 1986 report by the American Association of Retired Persons, entitled "Workers Over 50: Old Myths, New Realities," found that 62 percent of responding firms found that the extra cost of health insurance for employees age 50 and over to be insignificant compared with total company health care costs. Only 16 percent of the employers rated a 55-year-old employee as being extremely costly to insure, as compared to 34 percent of firms which rated a 30-year-old with two dependents very expensive to insure.

Employer's concerns about the rising cost of providing health insurance for older workers, however, has been worsened by recent legislative action. In the last decade there has been an increasing trend by the Federal Government to seek ways to curb the rising costs of Medicare by shifting costs to private payors. The Tax

Equity and Fiscal Responsibility Act of 1982 (TEFRA), legislated changes in Medicare coverage for older workers. As of January 1983, employers could no longer advise workers that they were to be dropped from company group health insurance plans at age 65 because they were eligible for Medicare. TEFRA requires that company plans bear the primary insurance costs of illness, while Medicare becomes secondary. The TEFRA requirement raised employer costs in two ways. First, costs will rise for employees age 65 through 69 who previously were covered by employer plans, because these plans now are the primary payer of benefits. Second, employees age 65 through 69 who previously were excluded from employer health plans must now be covered if the employer offers a plan to any of its employees.

A report released in June 1983, by ICF, Inc., estimated that about 434,000 private sector workers age 65 through 69—about 37 percent of all private sector workers in this age group—were affected by these changes, at a total cost to employers of about $500 million. About 286,000 or 66 percent, of these workers were previously covered by employer plans. The additional health plan costs for these workers are estimated to be about 8 percent of their total compensation costs before the amendments. In addition, about 148,000 workers who were previously excluded from coverage are likely to be covered by employer plans. The health plan costs of these workers is estimated to be about 13 percent of their total compensation costs before the amendments. The study concluded that these changes would initially reduce the demand for workers of this age by about 1 percent.

Two major provisions in the Deficit Reduction Act of 1984 (DEFRA) also have some effect on the costs of employing older workers and on the costs to older workers of remaining employed longer. The first is section 2301 of DEFRA, which modified the working aged provision—originally included in TEFRA—so that an employer must offer group health coverage to an employee who has not reached age 65 if the employee has a spouse age 65 through 69. If such an employee elects the group coverage—versus Medicare coverage for the spouse—the employer must offer coverage that is the same as that offered to employees with spouses under age 65. In such cases, Medicare would be the secondary payer, while the employer sponsored plan would be primary. The implications of this provision for employers are relatively minor when taken alone, but when added to the effects of already existing cost factors they are significant. Now employers have yet another reason not to hire or retain older workers—those under age 65—because if they have an older spouse, the employer, rather than Medicare, is required to pay the health costs for the spouse. These added costs may encourage employers to steer clear of older workers.

The second provision, section 2338 of DEFRA, removed a disincentive to older workers for remaining on their employer's health plan. Under the TEFRA provision, those employees who elected, after age 65, to remain in the employer health plan would have been penalized for not enrolling in part B of Medicare upon their 65th birthday. This penalty amounted to a 10-percent increase on annual premiums for each 12 months that the employee does not enroll after his or her 65th birthday. Since the Medicare coverage was duplicative of the employer plan there was no need to enroll in part B until after retirement—except for the stiff penalty imposed. DEFRA waived the part B premium for workers and their spouses aged 65 through 69 who elect private coverage under the provisions of TEFRA. It also established special enrollment periods for such workers. The waiver applies for the period during which an individual continues to be covered under an employer's group health plan.

Finally, employers health care insurance obligations to older employees under the ADEA were expanded by the fiscal 1986 budget reconciliation bill (P.L. 99-272). The law removed the upper age limit of 69 and employers are now required to offer employees and their spouses aged 69 and over the same group health insurance coverage provided to younger workers.

Another issue is the difficulty some employers—particularly those with few employees—are having in finding adequate health insurance coverage for their older workers. Indeed, in 1983 the Wall Street Journal reported that insurance companies know that groups containing older people will run up bigger medical bills than those with younger participants. As a result, insurance premiums for the group plans have soared and some insurance companies have gotten out of the small-group business altogether because they concluded these plans were unprofitable. Higher insurance premiums for veteran employers create another disincentive for those employers to hire and retain older workers.

Despite concerns among employers about the costs of older workers, the Federal Government is seeking ways of keeping older workers in the labor force. The most notable examples of this are the 1983 amendments to the Social Security Act. The compromises that resulted in the amendments (P.L. 98-21) reflect the belief in Congress that older people are healthier today and, therefore, can continue to work longer. The desired effect of the amendments is that older workers will be discouraged from leaving the labor force by an increase in the penalty for early retirement, an increase in the age at which full retirement benefits are paid, an increase in the delayed-retirement credit, and a reduction in the penalty on earnings after retirement.

2. The Age Discrimination in Employment Act

(A) TENURED FACULTY EXEMPTION

Provisions in the 1986 amendments to the ADEA to temporarily exempt universities from the law reflect the continuing debate over the fairness of the tenure system in institutions of higher education. During consideration of the 1986 amendments, several legislative proposals were made to eliminate mandatory retirement of tenured faculty, but ultimately a compromise allowing for a temporary exemption was enacted into law.

The exemption allows institutions of higher education to set a mandatory retirement age of 70 years of persons serving under tenure at institutions of higher education. This provision is in effect for 7 years, until December 31, 1993. The law also requires the EEOC to enter into an agreement with the National Academy of Sciences to conduct a study to analyze the potential consequences of the elimination of mandatory retirement for institutions of higher education. The study findings are to be submitted to the President and to Congress within 5 years of enactment. The law sets forth the composition of the study panel to include administrators and teachers or retired teachers at institutions of higher education.

Most agree that the tenure system is different from many other employment situations. Tenure protects academic freedom by prohibiting dismissals except under specific conditions. Many have argued that without mandatory retirement at age 70, institutions of higher education will not be able to continue to bring in those with fresh ideas. The older faculty, it is claimed, would prohibit the institution from hiring younger teachers who, with their current state of knowledge, are better equipped to service the needs of the school. The argument also is made that allowing older faculty to teach or research past the age of 70 denies women and minorities access to the limited number of faculty positions.

Opponents of the exemption claim that there is little statistical proof that older faculty keep minorities and women from acquiring faculty position. Indeed, they cite statistical information gathered at Stanford University and analyzed in the paper by Allen Calvin which suggests that even with mandatory retirement and initiatives to hire more minorities and women, there was only a slight change in the percentage of tenured minority and women faculty.

Proponents of an exemption cite a study by the Labor Department that the salaries of faculty nearing retirement are about twice those of newly hired faculty. Accordingly, they argue that prohibiting mandatory retirement might also exacerbate the financial problems many colleges and universities are facing.

Those who oppose the exemption believe that there are not sufficient reasons to single out faculty for special, discriminatory treatment. They call it double discrimination—once on the basis of age and again on the basis of occupation—and argue that colleges and universities are using mandatory retirement to rid themselves of both undesirable and unproductive professors, instead of dealing directly with a problem that can afflict faculty members of any age. The use of performance appraisals, they argue, is a more reliable and fair method of ending ineffectual teaching service than is age. Finally, they claim that there is no evidence that many professors would stay past 70 even if they could, and that predictions of dire consequences from uncapping the retirement age may be exaggerated. According to the Teachers Insurance Annuity Association and College Retirement Equities Fund, the average age at which faculty members begin collecting their pensions—which usually represents a retirement date—has been declining over the past 10 years.

(B) STATE AND LOCAL PUBLIC SAFETY OFFICER PROVISION

As previously noted, the ADEA allows an exception against age discrimination in the workplace where "age is a bona fide occupational qualification (BFOQ) reasonably necessary to the normal operation of a particular business, or where the differentiation is based on reasonable factors other than age." The BFOQ defense has been most successful in cases that involve the public safety. In general, courts have allowed maximum hiring ages and mandatory retirement ages for bus drivers and airline pilots, and, on occasion, police officers and firefighters because the safety of the public was at stake. The courts, however, have been inconsistent and the lack of clear judicial guidance has prompted calls for reform.

Under the 1986 amendments to the ADEA, a temporary exemption from the law was provided for State and local public safety officers. The provision is in effect for 7 years, until December 31, 1993.

The 1986 amendments also required the Secretary of the Department of Labor and the EEOC to conduct a study and to report to Congress on whether physical and mental fitness tests can be used as a valid measure to determine the competency of police officers and firefighters and to develop recommendation on standards that such tests should satisfy. The study is to be submitted to Congress within 4 years of enactment of the law. The law also requires that within 5 years of enactment, the EEOC proposes guidelines for the administration and use of physical and mental fitness tests to measure the ability and competency of police and firefighters to perform their jobs.

The issue of whether public safety officers should be treated like other employees under the ADEA arose after the Supreme Court, on March 2, 1983, in *EEOC* v. *Wyoming*, determined that the State's game wardens were covered by the ADEA. Wyoming's policy of mandatory retirement at age 55 for State game wardens was ruled invalid unless the State could show that age is BFOQ for game wardens. Wyoming had not attempted to establish a BFOQ in this case, but had instead argued that application of the ADEA to the State was precluded by constraints imposed by the 10th amendment on Congress' commerce powers—an argument not sustained by the Court.

In addition, in June 1985, the Supreme Court rendered two decisions in cases arising under the ADEA favorable to employees who had challenged the mandatory retirement policies of their employers. The first case, *Johnson* v. *Mayor and City Council of Baltimore*, 472 U.S. 353 (1985), involved six firefighters who challenged the City of Baltimore's municipal code provision that established a mandatory retirement age at 55 for firefighters. The Court of Appeals, accepting the city's argument, had held that the Federal civil service statute, which requires most Federal firefighters to retire at age 55, constituted a BFOQ for the position of firefighters employed by the city. The Supreme Court reversed this decision, stating that nothing in the *Wyoming* decision or the ADEA warrants the conclusion that a Federal rule, not found in the ADEA, and by its terms applicable only to Federal employees, necessarily authorizes a State or local government to maintain a mandatory retirement age as a matter of law. The Court found that it was Congress' indisputable intent to permit deviations from the mandate of the ADEA only in light of a particularized, factual showing. The Court concluded that Congress' decision to retire certain Federal employees at an early age was not based on a BFOQ, but instead dealt with "idiosyncratic" problems of Federal employees in the Federal civil service. Accordingly, the Court ruled that a State or private employer cannot look to exemptions under Federal law as dispositive of BFOQ exemptions under the ADEA. There is a need, the Court said, to consider the actual tasks of the employees and the circumstances of employment to determine when to impose a mandatory retirement age.

The second case, *Western Airlines, Inc.* v. *Criswell,* 472 U.S. 400 (1985), raised a challenge under the ADEA to Western Airline's requirement that flight engineers, who do not operate flight controls as part of the cockpit's crew unless the pilot and co-pilot become incapacitated, were subject to mandatory retirement at age 60. The Supreme Court upheld a jury verdict for the plaintiffs against an airline defense that the age 60 requirement constituted a BFOQ. The Court confirmed that the BFOQ defense is available only if it is reasonably necessary to the normal operation or essence of a defendant's business. The Court also noted that an employer could establish this defense only by proving that substantially all persons over an age limit would be unable to perform safely and efficiently the duties of the job, or that it would be impossible or highly impractical to deal with older employees on an individualized basis.

In both of these cases, a unanimous Court seemed to be looking very critically upon attempts to expand the BFOQ defense beyond specific high risk occupations. The Court also stressed the relationship between individual performance and employment in a particular task, rather than reliance on a standard of chronological age disqualification. Thus, by adopting a very narrow reading of the BFOQ exemption, the Court appears to have strongly endorsed individualized determinations.

Many States and localities with mandatory retirement age policies below age 70 for public safety officers were concerned about the impact these decisions were going to have. As of March 1986, 33 States or localities had been or were being sued by the EEOC for the establishment of mandatory retirement or minimum hiring age laws. Amid these actions, legislation was proposed to exempt public safety officers from some or all of the ADEA provisions.

Supporters of the exemption legislation argue that the mental and physical demands and safety considerations for the public, the individual, and coworkers who depend on each other in emergency situations, warrant mandatory retirement ages below 70 for these State and local workers. Also, they contend that it would be difficult to establish that a lower mandatory retirement age for public safety officers is a BFOQ under the ADEA because of conflicting court decisions and entail costly and time consuming litigation. They note that jurisdictions wishing to retain the hiring and retirement standards that they established for public safety officers prior to the Wyoming decisions are forced to engage in costly medical studies to support their standards. Finally, they question the feasibility of individual employee evaluations, some citing the difficulty involved in administering the tests because of technological limitations concerning what human characteristics can be reliably evaluated, the equivocal nature of test results and economic costs. They do not believe that individualized testing is a safe and reliable substitute for preestablished age limits for public safety officers.

Those who oppose an exemption contend that there is no justification for applying one standard to Federal public safety personnel and another to State and local public safety personnel. They believe that exempting State and local governments from the hiring and retirement provisions of the ADEA in their employment of public safety officers will give them the same flexibility that Congress granted Federal agencies which employ law enforcement officers and firefighters.

As an additional argument against exempting safety officers from the ADEA, opponents note that age affects each individual differently. They note that tests can be used to measure the effects of age on individuals, including tests that measure general fitness, cardiovascular condition, and reaction time. In addition, they cite research on the performance of older law enforcement officers and firefighters which supports the conclusion that job performance does not invariably decline with age and shows that there are accurate and economical ways to test physical fitness and predict levels of performance for public safety occupations. All that the ADEA requires, they argue, is that the employer make individualized assessments where it is possible and practical to do so. The only fair way to determine who is physically qualified to perform police and fire work is to test ability and fitness.

Lastly, those arguing against an exemption state that mandatory retirement and hiring age limits for public safety officers are repugnant to the letter and spirit of the ADEA, which was enacted to promote employment of older persons based on their ability rather than age and to prohibit arbitrary age discrimination in employment. They believe that it was Congress' intention that age should not be used as the principal determinant of an individual's ability to perform a job, but that this determination, to the greatest extent feasible, should be made on an individual basis. Maximum hiring age limitations and mandatory retirement ages, they contend, are based on notions of age-based incapacity and would represent a significant step backward for the rights of older Americans.

For occupations which can affect the public safety but which are not public safety officer occupations (such as airline pilots and bus drivers), the BFOQ defense still applies. In the case of *Tullis* v. *Lear School, Inc.*, 874 F.2d 1489 (11th Cir. 1989), the court found that a schoolbus driver had been terminated at the age of 65 in violation of the ADEA. The school failed to prove that as a group, all or most schoolbus drivers over the age of 65 are unable to perform their jobs safely, and the school failed to show that it was not feasible to individualize assessments of its bus drivers' medical qualifications. The EEOC currently has five cases pending which involve the forced retirement of schoolbus drivers.

(C) APPRENTICESHIP PROGRAMS

According to EEOC's current interpretation, apprenticeship programs are exempt from the proscriptions of the ADEA. This exemption, in effect, permits employers and labor unions to exclude men and women over age 40 from entering these programs solely because of their age.

The current interpretation has been in effect ever since 1969, when the DOL published interpretive guidelines which provided that apprenticeship programs are not subject to the requirements of the ADEA. Since then, the DOL has viewed the elimination of the exemption as detrimental to the promotion of such programs in the private sector since they are widely seen as a training program for youth in which the initial investment and training can be recouped over the apprentice's worklife. However, others contend that to exclude older workers from participation in bona fide apprenticeship programs is to deny them needed retraining opportunities. They argue that rapid technological changes often make the skills of older workers obsolete.

Upon receiving responsibility for upholding the ADEA in 1979, the EEOC began to explore the possibility of amending the old DOL interpretation. However, attempts to do so were unsuccessful. Subsequently, a 1983 decision in *Quinn* v. *New York State Electric and Gas Corp.*, 569 F. Supp. 655 (1983), held that neither the language of the ADEA nor its legislative history support a conclusion that Congress intended to exempt apprenticeship programs from the ADEA. Following this decision, the EEOC decided to reconsider the exemption. On June 13, 1984, the Commission unanimously voted to rescind the current exemption and issued proposed regulations which would prohibit arbitrary age discrimination in such programs. The regulations, however, languished before the Office of Management and Budget, apparently because the DOL has opposed the proposed change.

Finally, on July 30, 1987, the Commission reversed itself and voted against changing the old interpretation. According to EEOC Chairman Clarence Thomas, any decision to change that position would be "properly left for the Congress." This was the same day the Commission cited its broad authority to promulgate regulations in passing its rule (discussed below) permitting employees to waive their ADEA rights without EEOC supervision. By retaining the old DOL interpretation, EEOC has effectively precluded midlife and older workers seeking critical new jobs skills from receiving needed training through these programs.

(D) APPOINTED STATE JUDGES

Section 11(f) of the ADEA defines the term "employee," and specifically excludes "any person elected to public office in any State or political subdivision . . . or an appointee on the policymaking level . . . ." 29 U.S.C. section 630(f). Recently, a number of court cases have raised the issue whether an appointed State judge is excluded from the protections of the ADEA as "an appointee on the policymaking level."

In *Schlitz* v. *Virginia*, 681 F. Supp. 330 (E.D. Va. 1988), the court was considering an appointed State judge's challenge under the ADEA of Virginia's mandatory retirement of judges who reach the age of 70. The court stated that appointed State judges have all the characteristics of employees of the State, and absent some specific exclusion in the act, they are covered by the ADEA. After noting that the distinction that the Congress chose to make in section 11(f) was between elected and appointed State officials, the court held that appointed State judges were entitled to the protections of the ADEA and could not be forced to retire because of age.

The U.S. Court of Appeals for the First Circuit applied different reasoning in *EEOC* v. *Massachusetts*, 858 F.2d 52 (1st Cir. 1988).

Here the court found the elected versus appointed analysis unpersuasive. Instead, it reasoned that while appointed State judges are not "policymakers" in the same sense as executive or legislative appointees, they are necessarily policymakers as a function of judging. The court therefore held that appointed State judges fall within the "appointee on the policymaking level" exception and are not covered by the ADEA.

In *EEOC* v. *Vermont,* 717 F. Supp. 261 (D. Vt. 1989), the court strongly disagreed with the First Circuit's conclusion that appointed State judges are policymakers. "A judge's principal activity is to decide cases between litigants involving questions of law in which there are no interstices or lacunae to fill. In any event, gap-filling by judges is really a form of lawmaking, not policymaking", 717 F. Supp. at 264–65. The court found that appointed State judges do not fall within any of the section 11(f) exceptions, and it held that Vermont Supreme Court Justice Louis Peck is protected by the ADEA and cannot be forced to retire due to age.

The *Vermont* case is currently on appeal to the United States Court of Appeals for the Second Circuit, and if a conflict among the circuits develops, the U.S. Supreme Court may very well decide this issue.

(E) WAIVERS OF RIGHTS

Although certain substantive sections of the ADEA were taken from Title VII of the Civil Rights Act, Congress was careful to incorporate into section 7 of the ADEA the higher level of protection afforded by the Fair Labor Standards Act of 1938 (FLSA). The Supreme Court noted the incorporation of FLSA enforcement procedures into the ADEA in its decision in *Lorillard* v. *Pons,* 434 U.S. 575 (1978), stating that "[the] selectivity that Congress exhibited in incorporating provisions and in modifying certain FLSA practices strongly suggests that but for those changes Congress expressly made, it intended to incorporate fully the remedies and procedures of the FLSA."

Under the pre-ADEA caselaw dealing with contractual waivers of private rights under the FLSA, there were two Supreme Court cases which, taken together, may be interpreted to hold that FLSA rights cannot be privately waived. See *Brooklyn Savings Bank* v. *O'Neil,* 324 U.S. 697 (1945), and *Schulte, Inc.* v. *Gangi,* 328 U.S. 108 (1946). It would follow, then, that under the ADEA enforcement scheme nonsupervised private agreements to waive ADEA rights would also be impermissible.

In *Runyan* v. *National Cash Register Corp.,* 787 F.2d 1039 (6th Cir. 1986), however, a private release form purporting to waive all claims against an employer was held by the U.S. Court of Appeals for the Sixth Circuit to be binding under the ADEA. By a vote of 11 to 2, the court rejected the argument that an unsupervised private release of rights under ADEA is void as a matter of law. The court's holding was limited to the circumstances of the case where nothing indicated that the employer had exploited its superior bargaining power by forcing the employee to accept an unfair settlement.

Those who believe that unsupervised waivers of rights are, in fact, not permitted under the ADEA have been highly critical of the *Runyan* decision's overall applicability to the ADEA. The plaintiff in the case was an experienced labor attorney and, therefore, extremely knowledgeable of the law. This has prompted many to argue that *Runyan* is more the exception than the rule. Indeed, according to a 1981 Louis Harris survey conducted for the National Council on the Aging, over half the workers age 40 to 70 (those protected by the ADEA as of 1981) were unaware of the protections afforded them under the ADEA. Waiver opponents argue that, given this fact, it would be extremely difficult for most workers to execute knowing and voluntary waivers.

In the past, the EEOC recognized that application of the FLSA enforcement provisions to the ADEA could be interpreted to mean that individuals could not waive their rights or release potential liability even if the action is voluntary and knowing, except under EEOC supervision. On October 7, 1985, however, EEOC published in the Federal Register a Notice of Proposed Rulemaking to allow for non-EEOC supervised waivers and releases of private rights under the ADEA. Nearly 2 years later, on July 30, 1987, the EEOC approved a final rule to permit unsupervised waivers.

The exemption allows employers and employees to issue private agreements which contain waivers and/or releases or private rights under the ADEA without the supervision or approval of the EEOC. The Commission argued that the remedial purposes of the act would be better served by allowing agreements to resolve claims whenever employees and employers perceive them to serve their mutual interests, provided such waivers of rights are knowing and voluntary. To support this view, the Commission cites the similarities between the ADEA and Title VII of the Civil Rights Act of 1964 and notes that under Title VII, such unsupervised waivers of private rights are permissible.

However, in *Lorillard,* while the court acknkowledged that many of the ADEA's prohibitions were modeled after Title VII, it found significant differences in the remedial and procedural provisions of the two laws. The court stated that "rather than adopting the procedures of Title VII for ADEA actions, Congress rejected that course in favor of incorporating the FLSA procedures even while adopting Title VII's substantive prohibitions . . . [The] petitioner's reliance on Title VII, therefore, is misplaced."

In justifying its regulations, the EEOC heavily relies upon the *Runyan* case. Opponents of the rule, however, noted the limited scope of the *Runyan* decision and argued that such a narrow decision did not justify the EEOC's decision to grant blanket waivers of individuals' ADEA rights without Government supervision. Waiver opponents also cited the filing of a strong dissent in the case and note that EEOC's proposed regulation was cited in the final *Runyan* decision. Therefore, they argue, EEOC's heavy reliance on the court's ruling is somewhat misplaced.

In short order, the EEOC rule became the focal point of controversy, with a number of seniors' advocacy organizations and Members of Congress strongly opposing the EEOC's action. Although the EEOC claimed that the rule was in the best interest of the older worker, the Congress did not agree and enacted legislation to suspend the effect of the rule in fiscal years 1988, 1989, and 1990.

Following a September 1987 hearing of the Senate Special Committee on Aging, legislation to suspend the rule during the 1988 fiscal year was enacted in the fiscal year 1988 Continuing Resolution (P.L. 100-202). Nevertheless, at a May 24, 1988, hearing of the Senate Labor and Human Resources Subcommittee on Labor, a representative of the EEOC continued to defend the rule.

To provide sufficient time to develop a bipartisan policy in this area, legislation to extend the suspension through fiscal year 1989 was included in the fiscal year 1989 Commerce, Justice, State appropriation bill, enacted as Public Law 100-459. Close to the end of the 100th Congess, S. 2856, the proposed "Age Discrimination in Employment Waiver Protection Act" was introduced, with the backing of major seniors' groups, to resolve the issues surrounding unsupervised waivers. Except in the settlement of a bona fide age discrimination claim, the legislation would have barred unsupervised waivers of older workers' rights. Congress failed to act on this bill before the end of the 100th Congress.

S. 54, the "Age Discrimination in Employment Waiver Protection Act of 1989," was introduced by Senators Metzenbaum, Heinz, Pryor, and others early in the 101st Congress, and the suspension of the EEOC's waiver rule was extended through fiscal year 1990 by the fiscal year 1990 Commerce, Justice, State Appropriations bill (P.L. 101-162).

(F) OLDER WORKER EMPLOYEE BENEFITS

On June 23, 1989, the Supreme Court handed down what older worker advocates felt was a very disturbing decision in *Public Employees Retirement System of Ohio* v. *Betts*, 109 S.Ct. 2854 (1989). In the words of Justice Marshall, the Court's decision "immunize[d] virtually all employee benefit programs from liability under the Age Discrimination in Employment Act [(ADEA)]. . . ."

In 1967, when the Senate was considering the bill that would become the ADEA, then Senator Javits offered an amendment with the goal of insuring that employers would not be discouraged from hiring older workers by the fact that the cost of some benefits increases with age. This amendment, which would become section 4(f)(2) of the ADEA, created an exception from the proscriptions of the ADEA for bona fide employee benefit plan "which is not a subterfuge to evade the purposes of [the Act]. . . ." 29 U.S.C. section 623(f)(2).

The DOL issued a three paragraph regulations interpreting section 4(f)(2) in 1969. This regulation stated that "[a] retirement, pension or insurance plan will be considered in compliance with the statute where the actual amount of payment made, or cost incurred, in behalf of an older worker is equal to that made or incurred in behalf of a younger worker, even though the older worker may thereby receive a lesser amount of pension or retirement benefits, or insurance coverage." 29 C.F.R. section 860.120 (1969). This "equal benefit or equal cost" standard therefore became the test for an employee benefit plan's compliance with the ADEA.

In 1977, the U.S. Supreme Court decided *United Airlines, Inc.* v. *McMann*, 434 U.S. 192 (1977), in which a retirement plan was forcing the early retirement of older workers. The Court held that the term "subterfuge," as used in section 4(f)(2), has a plain meaning (a scheme, plan, stratagem, or artifice of evasion), and by definition an employee benefit plan adopted prior to the enactment of the ADEA in 1967 could never be a "subterfuge." The Court therefore ruled that this retirement plan fell within the section 4(f)(2) exception and did not violate the ADEA.

In 1978, Congress reacted to the *McMann* decision by amending section 4(f)(2) with the phrase "no such . . . employee benefit plan shall require or permit the involuntary retirement of any individual [protected by this Act] because of the age of such individual[.]", 29 U.S.C. section 623(f)(2). Congress also called on the DOL to further clarify its ADEA regulations.

During the Senate debate over the 1978 amendments to the ADEA, Senator Javits essentially endorsed the DOL's interpretation of section 4(f)(2) by clarifying what he had intended with his 1967 amendment:

> The purpose of section 4(f)(2) is to take account of the increased cost of providing certain benefits to older workers as compared to younger workers.
>
> Welfare benefit levels for older workers may be reduced only to the extent necessary to achieve approximate equivalency in contributions for older and younger workers. Thus a retirement, pension, or insurance plan will be considered in compliance with the statute where the actual amount of payment made, or cost incurred in behalf of an older worker is equal to that made or incurred in behalf of a younger worker, even though the older worker may thereby receive a lesser amount of pension or retirement benefits, or insurance coverage.

In response to the Congressional request, the DOL issued a more comprehensive version of the 1969 regulation. This expanded version was ultimately adopted by the EEOC when it took over enforcement of the ADEA in 1979. In its regulations the EEOC concluded that "[t]he legislative history of this provision indicates that its purpose is to permit age-based reductions in employee benefit plans where such reductions are justified by significant cost considerations.", 29 C.F.R. section 1625.10(a)(1). The EEOC then adopted the same equal benefit or equal cost interpretation contained in the 1969 Department of Labor regulation and used by Senator Javits in the 1978 floor debate. *Id.*

Until the Supreme Court handed down its decision in *Betts*, the equal benefit or equal cost test, although much litigated, was the official interpretation of the section 4(f)(2) exception to the ADEA. June Betts was a public employee in Ohio. At age 61 she became permanently and seriously disabled and had no choice but to retire. Ohio's Public Employee Retirement System (PERS), as enacted in 1933, provided for basic retirement and disability retirement. Disability retirement, however, is limited to employees under 60.

In 1976, PERS was amended to provide that disability retirement payments could never be less than 30 percent of the retiree's salary. Under basic retirement, Betts would have received $158.50 per month in benefits, and under disability retirement she would have received $355 per month. Betts was not allowed to take disability retirement because she was over 60, and she was forced to settle for basic retirement benefits. She filed suit in Federal court contending that the PERS plan discriminated against older workers in violation of the ADEA.

Using the EEOC's equal benefit or equal cost test, the district court held in favor of Betts, finding that PERS did not qualify for the section 4(f)(2) exception to the ADEA. The U.S. Court of Appeals for the Sixth Circuit affirmed the district court's decision.

In spite of a friend of the court brief submitted by the administration in support of the EEOC's regulation, the Supreme Court rejected this long-standing interpretation of the section 4(f)(2) exception, and instead adopted a "plain meaning" approach to the term "subterfuge." In doing so, the Court first reaffirmed its 1977 ruling in *McMann* that an employee benefit plan adopted prior to the enactment of the ADEA in 1967 could not be a subterfuge to evade the purposes of the act. In other words, discriminatory pre-ADEA benefit plans can never be found to be unlawful under the ADEA. However, since PERS was amended in 1976, the Court could not dispose of the case on that basis.

Next, the Court held that a post-ADEA employee benefit plan does not violate the ADEA "so long as the plan is not a method of discriminating in other, nonfringe-benefit aspects of the employment relationship. . . ." In other words, it is not a violation of the ADEA for an employer to discriminate against an older worker in terms of employee benefits as long as the benefit plan is not a vehicle for discrimination in other prohibited ways, such as salary, hiring, or firing. Further, the Court held that an employee challenging an employee benefit plan under the ADEA has the burden of proving that the plan discriminates in some nonbenefit way. Based on these holdings, the Court reversed the lower court decision.

Advocates of elderly workers are very concerned about the large loophole left in the ADEA by the *Betts* decision. In addition, the EEOC is concerned because it has over 30 cases pending which could be dismissed based on the Supreme Court's decision. The business community contends that the equal benefit or equal cost regulation was not widely accepted and that the law in this area was anything but settled prior the Court's decision. A number of large employers and business associations believe that *Betts* was correctly decided and should be allowed to stand.

Congressional concern over the *Betts* case has resulted in three bills aimed at legislatively overturning the Court's decision. S. 1293 was introduced by Senator Heinz on July 11, 1989. S. 1511 was introduced on August 3, 1989, by Senators Pryor, Jeffords, Metzenbaum, Kennedy, DeConcini, and Bumpers. Senators Levin, Cohen, Glenn, Graham, Moynihan, Bentsen, and Bryan have since joined as cosponsors. S. 1511's House companion, H.R. 3200, was introduced on August 4, 1989, by Congressmen Roybal, Hawkins, Clay, Martinez and Bilbray, and currently has 37 cosponsors.

S. 1511/H.R. 3200 would amend section 4(f)(2) by deleting the term "subterfuge" and codifying the EEOC's long-accepted equal benefit or equal cost test. The bills would also assure that pre-1967 employee benefit plans are subject to the provisions of the ADEA, and assure that the 4(f)(2) exclusion is an affirmative defense under the ADEA, and the employer has the burden of proving that defense. The major difference between these bills and S. 1293 is that S. 1511/H.R. 3200 would apply retroactively to the day before the *Betts* decision.

On September 21, 1989, H.R. 3200 and the *Betts* decision were the subjects of a joint hearing of the House Select Committee on Aging and the House Education and Labor Subcommittees on Employment Opportunities and Labor-Management Relations. The Senate Special Committee on Aging and the Labor and Human Resources Subcommittee on Labor held a joint hearing on S. 1293 and S. 1511 on September 27, 1989.

(G) PENSION ACCRUAL PROVISIONS

In May 1979 the DOL published an interpretation bulletin regarding the 1978 ADEA amendments. The interpretation allowed employers with pension plans regulated under the Employee Retirement Income Security Act (ERISA) to cease pension contributions and pension credits for active employees who worked beyond the normal retirement age specified in their pension and retirement plans.

The EEOC, which assumed enforcement responsibility of the ADEA shortly after, initiated a review of its pension accrual policy in 1983. After evaluating hundreds of comments from individuals and groups, the majority of whom opposed the interpretive bulletin, EEOC commissioners in 1984 voted to rescind the bulletin and to require employers to continue to post credits to the pensions of workers beyond the normal retirement age. Subsequently, proposed regulations were drafted by the EEOC mandating continued pension accrual, which the Commission in 1985 unanimously approved.

Poised to implement the new policy regarding pension accrual for workers over 65, the EEOC in 1986 instead reversed directions, abandoning all rulemaking on continued pension accrual and refusing to rescind the bulletin. Although the EEOC also was ordered by the court to issue a new rule governing continued pension accrual, this portion of the ruling was reversed upon appeal.

After extended debate on this issue, provisions were included in the 1986 ADEA amendments to require employers to continue accrual of pension credits to workers beyond the normal retirement age, effective January 1988. More specifically, the law required pension coverage for all workers without regard to age, excepting (1) defined-benefit plans that increase the worker's retirement actuarially to reflect a benefit date that occurs after the month in which the worker turns 65, and (2) plans which limit the amount of benefits or limit the number of years of service or years of participation. Under Public Law 99-509, the Internal Revenue Service (IRS), followed by the EEOC and the DOL, were required to develop regulations in accordance with the new law.

Unfortunately, the new law was vague as to whether the new law was intended to be applied on a retroactive basis. Initially, the EEOC contended that the law did not require employers to take post credits for older workers for years served prior to the law's effective date, a position that was estimated to cost older workers $3 billion in lost pension benefits.

However, a complex rule proposed in April 1988 by the IRS, the lead agency, provides that in defined-benefit plans—namely, plans which promise a retired worker a set pension based on number of years of employment and a percentage of compensation—all years of service must be taken into account in determining retirement benefits. In contrast, with respect to defined-contribution plans—those in which an employer pledges to allocate a certain percentage of compensation each year toward the worker's pension—the law would not be applied retroactively under the IRS ruling.

Thus, under the IRS rule, a worker with a defined-benefit plan and who turns 65 prior to 1988 would accrue pension credits for years of service prior to the law's 1988 effective date. However, if the same worker was covered by a defined-contribution plan, only employment after January 1988 would be credited. According to the IRS, until a final rule is issued, the proposed regulations are in effect. In early 1989, the EEOC backed away from its earlier opposition and intends to conform to the IRS position.

(H) AGE DISCRIMINATION AWARENESS

Age discrimination continues to pervade the American workplace. While many industries recognize the value of hiring experienced older workers, others continue in their attempts to subvert the law. In addition, not only do many older workers fail to realize when they are being discriminated against, but many do not understand their rights and protections under the Age Discrimination in Employment Act. According to a 1981 Louis Harris survey, approximately half of the older workers polled were unaware of their ADEA rights and protections. Given the fact that no concerted awareness campaign has taken place since that time, these statistics are unlikely to have improved.

In response to this lack of awareness, legislation was enacted in 1987 to require the Department of Labor to furnish Title V contractors with printed materials regarding age discrimination in employment. The contractors will, in turn, distribute this information to program participants to apprise them of their lawful rights.

The Senior Community Service Employment Program under Title V of the Older Americans Act provides many seniors with needed jobs and income. Title V is the most visible federally supported employment program and is one of the few remaining job creation programs. For this reason, supporters of the amendment believe that Title V contractors will provide an excellent vehicle for increasing awareness.

3. The Job Training Partnership Act

During the 1st session of the 101st Congress, the Job Training Partnership Act was the subject of much discussion. While most agree that JTPA has been effective since its enactment in 1983, the Department of Labor and several Members of Congress believe that adjustments to the act are necessary in order to meet the changing needs of our Nation's work force.

In particular, much of the discussion has centered on the idea of cutting back or eliminating State-level set-asides, including the Title II-A set-aside for training and placement of older workers, and concentrating more resources at the local level through the service delivery areas (SDAs). Supporters of this idea feel that more services are needed at the local level, and specifically more job training services are needed for inner-city youth.

Possible elimination of the Title II-A older worker set-aside has caused concern among advocates for the elderly, who argue that youth are not the answer to future shortages in the work force. Secretary of Labor Elizabeth Dole recognized the importance of older workers when she stated in the October 1989 edition of *Aging News Network:*

> Experience, maturity, know-how, dependability—these and other positive traits that characterize older workers have always been important to any nation that wants to build and maintain a strong, competitive economy. But as we look to the dawn of a new century, they may be especially critical to our Nation's need to compete in today's global marketplace.
>
> All of this means that we can ill afford policies or practices that discourage skilled, experienced, productive men and women from continuing to work past retirement age if they want to do so.

Supporters of the Title II-A older worker provision contend that while programs funded by the set-aside generally started slowly in the first years, the vast majority of them are now very successful and should not be eliminated. Two bills have received the most attention.

(A) THE SIMON BILL

On March 8, 1989, Senator Paul Simon introduced S. 543, the "Job Training Partnership Act Youth Employment Amendments of 1989." As introduced, the bill would reallocate JTPA resources in order to provide more services to inner-city youth. In accomplishing this goal, the bill would have reduced the older worker set-aside from 3 percent to 2 percent.

An amended bill was reported by the Senate Labor and Human Resources Committee on July 26, 1989. The title was changed to the "Job Training and Basic Skills Act of 1989," and, in addition, the older worker set-aside was completely eliminated. In its place is a requirement that 5 percent of the adults served by the SDAs must be 55 years of age or older. Older worker advocates feel that this participant-based set-aside will not ensure service of sufficient types or amounts, and they contend that a dollar-based State-level set-aside is the best and only way to guarantee quality service for this age group.

(B) THE HAWKINS BILL

Congressman Augustus F. Hawkins introduced H.R. 2039, the "Job Training Partenership Act Amendments of 1989," on April 18, 1989. Like S. 543, H.R. 2039 would reallocate JTPA resources with an emphasis on serving inner-city youth. This bill would completely eliminate the Title II-A older worker set-aside and replace it with a mandate to the SDAs to make special efforts to serve adult workers 55 years of age or older.

C. PROGNOSIS

A variety of issues must be resolved in the years to come with respect to the employment of older and midlife workers. One such issue is whether to once again include age discrimination in employee benefits under the proscriptions of the ADEA. Legislation to overturn the Supreme Court's decision in *Betts* is rapidly gaining momentum and could be acted upon by the 101st Congress early in the 2d session. The related issue of ADEA waivers will also likely receive consideration in 1990.

Still another issue is whether to maintain JTPA's commitment to ensuring that disadvantaged older workers receive much needed job training and placement services. The Simon and Hawkins JTPA amendments seem to abandon this commitment and lump older workers, who have unique employment problems and needs, with younger adults. The Senate will probably face this issue in the 2d session, but the prognosis in the House is uncertain.

Other issues include whether to extend ADEA protection to tenured university faculty, public safety officers and older workers in apprenticeship programs. Although sterotypes abound about regarding unproductive, fractious older employees, there is a growing realization that older workers are a very diverse group.

The phenomenon of an aging work force presents a variety of potential problems, especially when considered in tandem with the trend toward early retirement. In attempting to downsize their work force, many companies chose to absorb the cost of offering early retirement packages to their employees. However, there is growing concern that in so doing, many companies merely consider short-term savings without regard to long-term costs due to lost experience, increased pension liabilities, and increased training costs.

As the Nation's population ages, there will be additional pressures to maintain an older work force. This will likely result in the eventual conclusion by business interest that it is to their advantage to modify their current employment practices and provide incentives for older workers to remain on the job. As this occurs, there may well be less of a need for Federal intervention to assure that older Americans are not victimized by age discrimination. However, until the advantages of employing and retaining older workers are widely acknowledged by business, it will remain essential that older persons who desire to work can rely on the EEOC to protect their rights under the ADEA.

Chapter 5

SUPPLEMENTAL SECURITY INCOME OVERVIEW

OVERVIEW

In 1972, the Supplemental Security Income (SSI) program was established to help the Nation's poor aged, blind, or disabled meet their most basic needs. The program was designed to supplement the income of those whose work experience and circumstances did not qualify them for Social Security benefits or whose Social Security benefits were not adequate for subsistence, and to provide recipients with the opportunity for rehabilitation and incentives to seek employment. In 1989, 4.5 million individuals received assistance under the program.

To those who meet SSI's nationwide eligibility standards, the program provides monthly payments. Importantly, in most States SSI eligibility automatically qualifies recipients for Medicaid coverage and Food Stamps benefits.

Under the Gramm-Rudman-Hollings Act, SSI benefit payments are exempted from any across-the-board budget cuts under that law. As a result, program benefits have thus far escaped budget cuts. The concern remains, however, whether SSI will remain intact as pressure to reduce the Federal budget deficit intensifies and competition for restricted funding escalates.

Although SSI has escaped the budget ax, the lack of additional funding for benefit increases has meant that the program continues to fall far short of eliminating poverty among the elderly poor. Despite progress in recent years in alleviating poverty among this group, a substantial number remain poor. When the program was started almost two decades ago, some 14.6 percent of the Nation's elderly lived in poverty. In 1989, the elderly poverty rate was 12 percent.

The effectiveness of SSI in reducing poverty is hampered by inadequate benefit levels, stringent financial criteria, and a low participation rate. In most States, program benefits do not provide recipients with an income that meets the poverty threshold. Nor have the program's allowable income and assets level kept pace with inflation. Further, only about half of those poor enough to qualify for SSI actually receive program benefits.

In recent years, the gulf between SSI's reality and its potential as an anti-poverty weapon has given rise to a growing movement among advocates and a number of Members of Congress to try and correct the program's inadequacies. In the 101st Congress, these efforts produced legislative proposals to bring the benefit standard to the poverty level, increase the program's income and assets levels, and mandate SSI outreach. In addition, a number of other program reforms were proposed.

Among the additional issues which provoked SSI reform legislation in 1989 was the lack of oversight of representative payees by the Social Security Administration (SSA), the agency charged with carrying out the SSI program. Following intense scrutiny by the Congress, comprehensive bills to strengthen monitoring were introduced and advanced in both Chambers.

At the conclusion of 1989, most of the SSI proposals were still pending, but expected to receive continued attention at the resumption of the 101st Congress in 1990. Even so, a number of technical, but significant improvements of the SSI program were enacted at the end of the first session.

In the midst of these Congressional activities, 1989 also witnessed a change in the leadership of SSA. In keeping with the prerogatives of a new President, in July of that year George Bush nominated Gwendolyn S. King as the new Commissioner of the agency. Within days, the Senate unanimously confirmed the President's choice, and since that time Commissioner King has maintained a bipartisan and accessible tone in her dealings with the Congress.

A. BACKGROUND

The SSI program, authorized in 1972 by Title XVI of the Social Security Act (P.L. 92-603), began providing a nationally uniform guaranteed minimum income for qualifying elderly, disabled, and blind individuals 2 years later. Underlying the program were three congressionally mandated goals: To construct a coherent, unified income assistance system; to eliminate large disparities between the States in eligibility standards and benefit levels; and to reduce the stigma of welfare through administration of the program by SSA. It was the hope, if not the assumption, of the Congress that a central, national system of administration would be more efficient and eliminate the demeaning rules and procedures that had been part of many State-operated public assistance programs. SSI consolidated three State administered public-assistance programs: Old age assistance; aid to the blind; and aid to the permanently and totally disabled.

Under the SSI program, States play both a required and an optional role. They must maintain the income levels of former public-assistance recipients who were transferred to the SSI program. In addition, States may use State funds to supplement SSI payments for both former public-assistance recipients and subsequent SSI recipients. They also have the option of either administering their supplemental payments or transferring the responsibility to SSA.

SSI eligibility rests on definitions of age, blindness, and disability; on residency and citizenship; on levels of income and assets; and, on living arrangements.

The basic eligibility requirements of age, blindness, or disability have not changed since 1974. Aged individuals are defined as those 65 or older. Blindness refers to those with 20/200 vision or less with the use of a corrective lens in the person's better eye or those with tunnel vision of 20 degrees or less. Disabled persons are those unable to engage in any substantial gainful activity because of a medically determined physical or mental impairment that is expected to result in death or that can be expected to last, or has lasted, for a continuous period of 12 months.

As a condition of participation, the SSI recipient also must reside in the United States or the Northern Mariana Islands and be a U.S. citizen, an alien lawfully admitted for permanent residence, or an alien residing in the United States under color of law.

In addition, eligibility is determined by a means test under which two basic conditions must be satisfied. First, after taking into account certain exclusions, monthly income must fall below the benefit standard—$368 for an individual and $553 for a couple in 1989. Second, assets must meet a variety of criteria.

Under the program, income is defined as earnings, cash, checks, and items received "in kind," such as food and shelter. Not all income is counted in the SSI calculation. For example, the first $20 of monthly income from virtually any source and the first $65 of monthly earned income plus one-half of remaining earnings are excluded and labeled as "cash income disregards." Also excluded are the value of social services provided by federally assisted or State or local government programs such as nutrition services, food stamps, or housing, weatherization assistance; payments for medical care and services by a third party; and in-kind assistance provided by a nonprofit organization on the basis of need.

In determining eligibility based on assets, the calculation includes real estate, personal belongings, savings and checking accounts, cash, and stocks. Assets that are not counted include the individual's home; household goods, and personal effects with a limit of $2,000 in equity value; $4,500 of the current market value of a car (if it is used for medical treatment or employment it is completely excluded); burial plots for individuals and immediate family members; a maximum of $1,500 in burial funds for an individual and the same amount for a spouse; and the cash value of life insurance policies with face values of $1,500 or less.

In 1989 and years thereafter, the asset limit is $2,000 for an individual and $3,000 for a married couple. The income of an ineligible spouse who lives with an SSI applicant or recipient is included in determining eligibility and amount of benefits.

The Federal SSI benefit standard also factors in a recipient's living arrangements. If an SSI applicant or recipient is living in another person's household and receiving support and maintenance from that person, the value of such in-kind assistance is presumed to equal one-third of the regular SSI benefit standard. This means that the individual receives two-thirds of the benefit. In 1990, the SSI benefit standard for individuals living in another person's household increased to $257 for a single person and $386 for a couple. If the individual owns or rents the living quarters or contributes a pro rata share to the household's expenses, this lower benefit standard does not apply. In 1988, 254,440 recipients, or 5.7 percent, came under this "one-third reduction" standard. Sixty-seven percent of those recipients were receiving benefits on the basis of disability.

When an SSI recipient enters a hospital, nursing home, or other medical institution in which a major portion of the bill is paid by Medicaid, the SSI benefit standard is reduced to $30 per month.

This amount is intended to take care of the individual's personal needs, such as haircuts and toiletries, while the costs of maintenance and medical care are provided through Medicaid.

B. ISSUES

1. BENEFITS

From the program's start-up in 1974, benefit levels have fallen below the poverty level. As a result, the program has relieved, but not eliminated, poverty rates among elderly and disabled individuals. The poverty rate among the elderly has declined only marginally from 14.6 percent in 1974 to 12 percent in 1988. For the black elderly, the poverty rate is even greater, at 32 percent. The poverty rate is highest for black elderly women, at 38 percent.

The 1989 benefit of $368 left an elderly individual 25 percent below the projected poverty level of $5,899. For elderly couples, the maximum benefit level of $553 was 11 percent below the projected poverty level of $7,442 in 1989. In 1988, out of a total population of 29 million elderly 65 and over, 3.5 million elderly had incomes below the poverty level.

A 1988 study by the National Council of Senior Citizens found that the average low-income elderly household had an annual income of $5,306. Of that amount, housing costs totaled more than 38 percent, food 34 percent, and home energy 17 percent. This left about $493, or $9.38 a week, for discretionary spending.

Under SSI, States also may voluntarily supplement the Federal SSI benefit. Approximately 42 percent of SSI recipients receive such supplementation. However, the median State supplement is only $36 for an individual per month and eight States provide no supplement. Only four States—Alaska, California, Massachusetts, and Connecticut—supplement SSI enough to bring benefits up to the poverty level.

In an effort to extend the effectiveness of SSI, anti-poverty advocates, joined by a number of national aging and disability organizations, spearheaded a campaign in 1989 to push for increasing the Federal benefit standard to the poverty level.

2. INCOME AND ASSETS LIMITS

An additional concern stems from the fact that the SSI program's cash income disregards have not been updated to reflect inflation. The Urban Institute has calculated that if the 1983 values of such disregards had been indexed they would have increased from the current $20 of monthly income from any source and $65 of monthly earned income to $40 and $30 respectively. The $20 disregard affects almost 90 percent of elderly beneficiaries.

Compounding this shortcoming is the absence of regular indexing for the asset limits individuals must meet to receive SSI benefits. Through the program's first 10 years the allowable asset limits remained constant at $1,500 for individuals and $2,250 for couples. In 1984, however, the Deficit Reduction Act (P.L. 98-369) raised these limits annually through 1989 by $100 for individuals and by $150 a year for couples. Even so, the concern remains among anti-poverty advocates that the asset test is still too stringent and disqualifies potentially eligible persons as a result.

The results of a 1988 study conducted by the Policy Center on Aging of Brandeis University, for the American Association of Retired Persons (AARP), support this contention. The study found that 34 percent of the income eligible 65–69 age group and 45 percent of the 85 and over age group were ineligible because of assets. The study also reported that a significant number of individuals possessed assets close to the cutoff. For example, about 60,000 elderly persons had countable assets that fell within $750 of the 1984 asset test threshold. The assets held by a majority of the asset ineligible population were interest earning accounts, homes, and automobiles. About half of income eligible/asset ineligible elderly households had modest life insurance policies that contributed to ineligibility.

Among the reforms of SSI that have been advocated to address this problem include elimination of the asset test, the use of the less stringent Food Stamp asset test in its place, and indexation of the asset test.

Using 1984 costs, the Brandeis study estimated the impact of such changes. Elimination of the asset test would be the most expensive, the study found, because it would increase the eligible population by 42 percent and increase the cost of Federal benefits by 34 percent, or between $800 million and $1.2 billion annually. Use of the Food Stamp test, which in 1988 permitted $3,000 in assets, would increase those eligible by 15 percent and Federal benefits by 12 percent, a total of between $300 million and $400 million. Indexing for inflation would increase the eligible population by 7 percent and increase Federal costs by 5 percent, or between $100 million and $200 million.

Overall, the Brandeis study raised the issue of whether the current SSI asset test furthers the Federal goal of alleviating poverty among the truly needy. The study concluded that many of the elderly are excluded from SSI not because they are well-off, but only because the Government has failed to take into account the impact of inflation on program eligibility criteria.

A broad coalition of anti-poverty advocates, in conjunction with a number of Members of Congress, included reform of the SSI program's income and asset tests among their priority objectives in the 101st Congress.

3. LOW PARTICIPATION

Since its inception, the SSI program has been plagued with low participation rates. Despite initial projections that over 7 million Americans were eligible for SSI, the caseload has never exceeded 4.5 million. Further, the number of elderly participants has continued to decline. The number of those 65 and over receiving SSI benefits declined from 2.3 million in 1975 to 1.4 million in 1989. A 1986 study by The Commonwealth Fund Commission on Elderly People Living Alone (The Commonwealth Fund) found evidence that those who are eligible but not participating are mostly elderly, single women living in poverty.

Over the years, studies have found that between 40 and 60 percent of the elderly poor enough to qualify for SSI actually receive benefits under the program. A 1980 study, based on 1975 population data, of the Institute for Research on Poverty found a 41 to 47 percent participation rate for the elderly. In the following year, 1981, Urban Systems reported a participation rate of 60 percent, using a nonrepresentative 1979 survey of low-income elderly.

More recently, a 1988 AARP study prepared under a grant from The Commonwealth Fund found that only 51.1 percent of the eligible elderly were participating in SSI, with rates varying between 30 to 60 percent among the States.

A related 1988 AARP survey, conducted by Lou Harris and Associates, found that over half of the eligible poor who were not participating in SSI had never heard of the program or did not know how to apply for assistance. Less frequenty cited reasons for nonparticipation included an inability to deal with the program's application process, language barriers, the stigma of receiving welfare, the loss of privacy, and the perception of low benefits.

Significantly, the AARP survey also identified a number of effective SSI outreach tools. The largest number of elderly respondents, 76 percent, reported that one-on-one assistance with the SSI application process would be an effective approach. About 72 percent reported that allowing individuals to set up an appointment time with SSA, rather than spending time waiting in an SSA field office, would further program participation. Slightly fewer, 68 percent, said that informing individuals that SSI eligibility confers access to health care through Medicaid would make a difference, followed closely by increasing benefits (67 percent) and allowing individuals to apply for SSI at some location other than an SSA field office (66 percent).

The findings of an April 1989 report of Families U.S.A., formerly the Villers Foundation, confirms that the major obstacle toward greater SSI participation among the elderly is a lack of information and understanding about the program. Based on a survey of over 6,000 low-income elderly, the study found that only one-third of the respondents knew that SSI could raise an eligible person's income and one-fourth were aware that SSI eligibility could lead to health care under Medicaid. The study also reported that the perceived complexity of the SSI application process and the lack of assistance in completing the application forms serves to keep many eligible individuals off the rolls. Finally, the report concluded that SSI outreach efforts on the part of SSA were limited, sporadic, and untargeted, and that a nationwide effort was critical to ensure that eligible individuals are able to receive the benefits under the program.

On a demonstration basis, AARP and The Commonwealth Fund worked in 1988 with dozens of local agencies in three cities to develop and test ways to increase participation in the SSI program. The projects pioneered a number of innovative strategies, making extensive use of the media, community education, and one-on-one counseling of potential SSI applicants. In the three cities—El Paso, Pittsburgh, and Oklahoma City—SSA reported an average increase of about 97 percent in applications and about 58 percent in awards.

In 1989, these projects served as templates for SSI outreach programs in 10 additional locations.

In recent years, SSA itself has undertaken some outreach activities, but they have been limited in scope and undertaken only after strong congressional pressure. In 1984, for example, a congressionally mandated effort by SSA to inform 7.6 million potential SSI recipients by mail of possible eligibility resulted in 79,000 applications—representing 1 percent of potential recipients who were alerted. A total of 58,000 of those who applied were awarded benefits.

The chronic low rates of program participation has led to criticism of the agency for failing to take a more aggressive approach to this problem and to provide better training to SSA staff in this area. Many also voice strong concern over the impact of the agency's closing of field offices, staff reductions in field offices, particularly field representatives and those with bilingual capability, and the lack of outreach efforts in minority communities.

Over the last several years, SSA resources most critical to the agency's outreach efforts—field representatives and contact stations—have been scaled back significantly. Between 1986 and 1989, the number of field representatives dropped by 28 percent and the number of contact stations by 22 percent.

Adding to the barriers to increased SSI participation was the nationwide implementation in 1989 of SSA toll-free line. Under the new system, all calls to SSA bypassed SSA field offices and were routed to a small number of SSA telephone centers. Promoted as a convenient way to get help from the agency, in its first year of operation the toll-free line was persistently plagued with a high incidence of busy signals and incomplete or erroneous answers, particularly with respect to the SSI program. An SSA study, conducted in the last months of 1988, revealed that nearly one in four callers (24 percent) with questions about SSI were given incorrect answers. (For a fuller discussion of SSA's toll-free line, please see chapter 21.)

4. Representative Payees

Under SSA's representative payee program, an individual other than the beneficiary is appointed to handle checks from the Social Security and SSI programs when the beneficiary is too disabled, or otherwise unable to manage his or her own finances. The monthly payments to approximately 1 million SSI beneficiaries are handled by representative payees. By definition, beneficiaries in need of a payee are vulnerable.

Intense concern over the lack of safeguards to protect beneficiaries from abuse by representative payees was triggered in November 1988 when police in Sacramento, CA, uncovered the bodies of eight Social Security beneficiaries in the backyard of Mrs. Dorothea Puente, an operator of an unlicensed board and care home. Mrs. Puente, who previously had been convicted for Social Security fraud, was the representative payee for one of the beneficiaries, whose murder she later was charged with committing.

At a March 1989 hearing of the House Social Security Subcommittee and a hearing a month later of the Senate Special Committee on Aging, a number of witnesses, including legal services attorneys and SSA claims representatives, characterized problems of abuse within SSA's representative payee program as pervasive. Witnesses pointed to SSA's lack of adequate screening and monitoring of payees as the major factors for these problems.

A 1983 study by SSA of payees under Social Security found problems with payees in as much as 20 percent of the time. Also, the study revealed that more than 4 percent of the cases called for a change in the payee, while 1.5 percent of those reviewed did not even need a payee. Limited in scope, this study excluded SSI recipients and relatives serving as payees.

Until 1978, SSA conducted limited monitoring of payees receiving Social Security. In that year, however, SSA discontinued this practice as a cost-saving measure. In the following year, SSA was challenged in a class action suit, known as the *Jordan* case, for abandoning its monitoring program and leaving beneficiaries vulnerable to abuse. In 1981, while the case was still pending, SSA also halted its monitoring program for payees under the SSI program.

Citing due process protections, in 1983 the court ruled in *Jordan* that SSA must conduct "mandatory periodic accounting" of *all* payees. Following a protracted but unsuccessful appeal by SSA, the agency ultimately was faced with a more stringent order to establish a monitoring program of "universal annual accounting." During this same period, legislation was enacted into law that would have exempted relatives from the monitoring requirements, but which the *Jordan* court subsequently voided.

Finally, to carry out the *Jordan* ruling, in 1988 SSA began requiring all payees to fill out a form listing estimated amounts of the expenditures in various categories. If the beneficiary or a third party contested the validity of the information provided by the payee, or the totals did not add up, only then was SSA required to look into the situation, typically by telephoning the payee and asking for an explanation. As a routine matter, SSA did not verify or audit the information provided by payees.

Although the policy of SSA is to investigate the fitness of an individual applying to serve as a payee, little in the way of a background check is conducted. Only in the wake of the Puente case has SSA begun to verify the applicant's identification and to *ask* if the applicant has ever been convicted of a felony. Under current law, individuals convicted of Social Security fraud violations are prohibited from serving as payees.

Recently, in *Holt* v. *Bowen*, a Federal district court ordered the agency to repay Mr. Holt, an SSI beneficiary whose lump sum benefits were stolen by a payee with a criminal record. The judge noted SSA was liable because the agency failed to conduct even a minimal investigation into the payee's background. Although the *Holt* case was not a class action suit, Mr. Holt's story illustrates the financial abuse to which beneficiaries are vulnerable, according to legal service attorneys and protective service workers.

5. EMPLOYMENT AND REHABILITATION FOR SSI RECIPIENTS

Section 1619 and related provisions of SSI law provide that SSI recipients who are able to work in spite of their impairments can continue to be eligible for reduced SSI benefits and Medicaid. The number of SSI disabled and blind with earnings has increased from 87,000 in 1980 to 176,000 in 1989. In addition, 22,000 of aged SSI recipients had earnings in 1989.

Before 1980, a disabled SSI recipient who found employment faced a substantial risk of losing both SSI and Medicaid benefits. The result was a disincentive for disabled individuals who could work or could have tried to work.

The Social Security Disability Amendments of 1980 (P.L. 96-265) established a temporary demonstration program aimed at removing work disincentives for a 3-year period beginning in January 1981. This program, which became Section 1619 of the Social Security Act, was meant to encourage SSI recipients to seek and engage in employment. Disabled individuals who lost their eligibility status for SSI because they worked were provided with special SSI cash benefits and assured Medicaid eligibility.

The Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460), which extended the Section 1619 program through June 30, 1987, represented a major push by Congress to make the disability program more effective. At that time, the House Ways and Means Committee asked the Department of Health and Human Services to evaluate the effectiveness of the Section 1619 program.

The original Section 1619 program preserved SSI and Medicaid eligibility for disabled persons who worked even though two provisions that set limits on earnings were still in effect. These provisions required that after a trial work period, work at the "substantial gainful activity level" (average countable earnings of over $300 a month up to 9 months) led to the loss of disability status and eventually benefits even if the individual's total income and resources were within the SSI criteria for benefits.

When an individual completed 9 months of trial work and was determined to be performing work constituting substantial gainful activity, he or she lost eligibility for regular SSI benefits 3 months after the 9-month period. At this point, the person went into Section 1619 status. After the close of the trial work period, there was, however, an additional one-time 15-month period during which an individual who had not been receiving a regular SSI payment because of work activities above the substantial gainful activities level could be reinstated to regular SSI benefit status without having his or her medical condition reevaluated.

The Employment Opportunities for Disabled Americans Act of 1986 (P.L. 99-643) eliminated the trial work period and the 15 month extension period provisions. Because a determination of substantial gainful activity was no longer a factor in retaining SSI eligibility status, the trial work period was recognized as serving no purpose. The law replaced these provisions with a new one that allowed use of a "suspended eligibility status" that resulted in protection of disability status of disabled persons who attempt to work.

The 1986 law also made Section 1619 permanent. The result has been a program that is much more valuable and useful to disabled

SSI recipients. The Congressional intent was to ensure ongoing assistance to the severely disabled who are able to do some work but who often have fluctuating levels of income and whose ability to work changes for health reasons or the availability of special support services.

Federal legislation is being considered which would begin to extend to Social Security Disability Insurance (SSDI) beneficiaries the same work incentives and cash benefits and/or medical coverage provided to those receiving SSI benefits under Section 1619.

This is of particular importance to elderly parents of adult mentally retarded or mentally ill children. At issue is the continued availability of income assistance, medical care, housing and social services for their children. Such services are often provided by the parents themselves, both financially as well as the day-to-day care and supervision of their adult disabled children. Many of these aging parents would like to set up trust accounts to provide for the children's care following their parents' death. However, the income from, and resources of, such a trust may cause a child to be ineligible for SSI and therefore unable to utilize the work incentive provisions of Section 1619.

Under present law, an individual must have 1 month of regular SSI benefits before they qualify for the work incentive provisions of Section 1619. The result is that an individual who is only receiving SSDI, when losing their disability status due to work activity, cannot move into the SSI Section 1619 program. The House of Representatives approved a provision which allows an SSDI recipient who becomes ineligible for SSDI as a result of earnings to participate in Section 1619 without first being required to receive at least 1 month of SSI benefits. This proposal, also included in a bill by Senator Riegle, is likely to receive close attention in 1990.

6. IMPROPER SUSPENSION OF BENEFITS

A SSA study, obtained by the Senate Special Committee on Aging in late 1989, revealed that the benefits of thousands of SSI recipients had been unfairly and improperly denied in 1986 and 1987. In view of the fact that individuals must have little in the way of financial resources to qualify for SSI, in addition to advanced age or a disabling condition, the suspension of benefits likely caused extreme hardship. Senate Aging Committee Chairman David Pryor announced that he was appalled by these actions.

In 1987, SSA suspended payments to over 80,000 SSI recipients on the grounds that they failed to respond to the agency's request for information concerning eligibility and payment status. In 1988, the number increased to over 105,000 individuals. A SSA analysis of a selected number of these cases showed that many of these suspensions were a result of an agency failure to allow the individuals in question sufficient time to respond. Even when the presence of a mental disability, advanced age, or a language barrier, the agency generally made no special effort to contact the recipients before cutting off their benefits. SSA policy requires that a follow-up contact be made in these cases.

A major factor for the lack of compliance with SSA policy requiring follow-up stems from a heavy workload, according to the study.

Also cited was a desire to avoid overpayment of benefits to recipients. In light of these findings, the study concluded that SSA must take special care in determining when to suspend benefits.

In response to the study's findings, Commissioner Gwendolyn King strongly criticized the staff of the agency over the handling of the SSI cases. In a speech to SSA staff the Commissioner stated, "I will not tolerate this happening again. If one, just one, beneficiary is wrongly denied his or her benefits, that is a tragedy, nothing less. We will not permit such a tragedy to take place." Five Senators, including Aging Committee Chairman David Pryor, Senator John Heinz, the Committee's Ranking Minority Member, and Senators Moynihan, Riegle, and Chafee, cosigned a letter to President Bush praising her decisive response to this problem.

C. CONGRESSIONAL RESPONSE

In response to the mounting concern over inadequacies of the SSI program, comprehensive reform legislation, along with a number of bills targeting specific program problems, were introduced in both Houses of Congress in 1989. Despite the ambitious scope and cost of these bills, the combined effort of a broad coalition of aging and disability organizations and key Members of Congress succeeded in advancing much of this legislation through key stages of the legislative process. At the conclusion of the first session of the 101st Congress, however, only a small number of provisions were actually enacted. The bulk of this SSI legislation was therefore awaiting further Congressional action in 1990.

1. Comprehensive Reform Legislation

Early in 1989, a coalition of Members in the House of Representatives—including, Representative Edward Roybal, Chairman of the Select Committee on Aging, and Representatives Robert Matsui and Downey—mounted a legislative campaign to increase the SSI benefit to the poverty level, raise the assets level from $2,000 to $4,200 for an individual (from $3,000 to $6,300 for a couple), mandate SSI outreach, and make a number of technical improvements to the program. These proposals were contained in H.R. 866, the "SSI Benefit Improvement Amendments of 1989" and H.R. 867, the "SSI Technical Amendments Act of 1989," respectively. Representatives Roybal and Downey also introduced separate, but identical legislation in H.R. 360 and 361 to raise the benefits and assets levels. The same provisions were included in the proposed Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), as passed by the House of Representatives. Due to an impasse between the House and the Senate over unrelated provisions in their respective versions of this bill, the SSI reforms were ultimately dropped and therefore were still pending at the end of 1989.

On the Senate side, Senator John Heinz, the Ranking Minority Member of Special Committee on Aging, also sponsored legislation in S. 665 to raise the SSI resource limit, require the establishment of an SSI outreach program, and reform a number of other SSI policies pertaining to disabled children. The bill was pending at the end of 1989.

2. SSI OUTREACH

Among the principle sponsors of SSI outreach legislation was Senator David Pryor, Chairman of the Special Committee on Aging. Provisions in his bill, S. 600, would require that SSA establish an SSI outreach program and work closely with nonprofit organizations toward this end. Although the Senate Finance Committee voted to include these provisions in its proposed reconciliation package, they were ultimately dropped from the final version of this legislation and were therefore still pending at the end of the first session of the 101st Congress.

As noted earlier, H.R. 866, H.R. 360, and S. 665 also contained provisions aimed at increasing the rate of participation in the SSI program, and also awaited further action in 1990.

Working on a separate legislative track to achieve the same goal of increased participation in the SSI program, $3.5 million in funding was included in the fiscal year 1990 Health and Human Services Appropriation Act (P.L. 101-166) to establish an SSI outreach program within SSA. Under the Act, SSA is encouraged to work with the Administration on Aging (AoA) and the Area Agencies on Aging in these efforts. (Although the Older Americans Act was amended in 1987 to create a new authorization for outreach services through AoA to older persons who may be eligible for SSI, Medicaid, and Food Stamps, no funds were appropriated.)

Amid widespread congressional concern over poor rates of SSI participation, the new SSA Commissioner Gwendolyn King announced at the start of her tenure in 1989 that SSI outreach would be among her top objectives.

3. REPRESENTATIVE PAYEES

In 1989, the Social Security Subcommittee of the House Ways and Means Committee and the Senate Special Committee of Aging each held hearings examining and exposing abuse within SSA's representative payee program. In response to this problem, legislation to establish stringent screening and monitoring standards was introduced and advanced in both Chambers in the first session of the 101st Congress.

Representative Jacobs, the Chairman of the Social Security Subcommittee, and Representative Levin pursued legislative reforms of the payee program as part of H.R. 3299 and H.R. 2422, respectively. Aging Committee Chairman David Pryor also proposed broad reforms of the program in S. 1130, mandating stringent screening and monitoring of individuals applying or acting as a payee.

Provisions from S. 1130 were included in the Senate's initial reconciliation package, but later dropped form that legislation for procedural reasons. The House provisions in H.R. 3299 also were ultimately stripped from the final OBRA package, and therefore awaiting further congressional action in 1990.

4. SSI TECHNICAL IMPROVEMENTS

On November 21, 1989, the House and Senate agreed to the conference report on H.R. 3299, OBRA 1989. The Act contains a number of technical, but important changes affecting adults in the

SSI program, including provisions to (1) disregard domestic commercial air, rail, and bus tickets given as gifts to SSI recipients; (2) treat a married couple as separate individuals beginning with the first month following the month of separation; (3) exclude interest and appreciation on the value of burial spaces in determining SSI income and resources, and (4) require that the value of property which is used in a person's trade or business, or in employment of a family member, be excluded from the equity value of the person's property.

D. PROGNOSIS

Over the last several years, in recognition of SSI's role as the major element in the Nation's safety net for poor elderly and disabled individuals, the Congress has exempted the program from budget cuts. Nevertheless, Federal spending constraints have precluded any program expansion and, as a result, SSI eligibility criteria have lost ground to the effects of inflation. At the same time, program benefits continue to lag behind the amount needed to pull recipients out of poverty.

In 1989, budgetary pressures frustrated congressional efforts to correct these program deficiencies. Nevertheless, in that year SSI legislation to liberalize eligibility criteria and raise the benefit standard made significant advances, marking the emergence of a renewed commitment to SSI reform.

No doubt in coming years the obstacles to achieving significant SSI expansion will continue to be difficult to overcome. An encouraging development in this area, however, is the decision of the coalition of aging and disability organizations, which mobilized key support for these reforms in 1989, to redouble its efforts in 1990 and beyond, under the banner of Campaign of Conscience. Nevertheless, to the extent that additional Federal resources are directed toward expanding SSI, they likely will be achieved on an incremental, rather than sweeping, basis.

In the near term, the prospects for enacting other significant SSI legislation—most particularly, bills to reform SSA's representative payee program—appear hopeful. In fact, only because of House and Senate disputes over issues unrelated to SSI was this legislation not enacted during the first session of the 101st Congress.

In 1990, continued congressional emphasis on SSI outreach efforts also can be expected. Similarly, congressional oversight of SSA is likely to ensure that SSA does not improperly suspend SSI benefits and that SSI recipients and others can get accurate and timely answers to questions over the agency's new toll-free line.

Chapter 6

FOOD STAMPS

OVERVIEW

Appropriations for the Food Stamp Program were authorized through fiscal year 1990 by the 1985 Food Security Act (P.L. 99-198). This same law made significant changes that liberalized the program and are expected to add more than $1 billion in new spending through 1990.

Since the 1985 reauthorization, Congress has made relatively minor revisions in the Food Stamp Program. For example, in 1986, Congress established an automatic system for verifying aliens' eligibility (P.L. 99-509) and limited the effect of Low-Income Home Energy Assistance Program (LIHEAP) benefits upon food stamp eligibility (P.L. 99-425).

A major exception to this general trend was the Hunger Prevention Act of 1988 (P.L. 100-435). This significant legislation increased food stamp benefits across-the-board; provided specific benefit increases for individuals with dependent care expenses and for certain disabled persons; eased eligibility for farm households; simplified the application process; and revamped the food stamp quality control system.

Perhaps in anticipation of the 1990 reauthorization of all major domestic agricultural programs (including food stamps), Congress made no major changes in the Food Stamp Program in 1989.

A. BACKGROUND

The Food Stamp Program attempts to alleviate malnutrition and hunger among low-income persons by increasing their food purchasing power. Under this program, the U.S. Department of Agriculture (USDA) issues food coupons that eligible households may use, in combination with other income, to purchase a more nutritious diet than would otherwise be possible.

In 1989, an estimated 20 million low-income persons participated in the program, with an average monthly benefit of slightly over $52 per person. This includes about 1.4 million persons a month in Puerto Rico under the nutrition assistance block grant program that has replaced the Food Stamp Program there. The Food Stamp Program is available to households which meet certain asset and income tests or which already receive benefits under the Aid to Families with Dependent Children (AFDC) or the Supplemental Security Income (SSI) programs. It is estimated that a minimum of 30 million people in the United States may actually be eligible to receive food stamps. Over the past decade, average monthly participation has ranged from a low of 17.7 million persons in fiscal year 1979 to a high of 23.2 million in fiscal year 1983.

The origins of the Food Stamp Program can be traced to an eight-county, experimental anti-hunger project established by Executive Order 1961. Today's Food Stamp Program began with the Food Stamp Act of 1964, which offered States the option of operating a Food Stamp Program in lieu of existing commodity donation projects. In 1977, Congress enacted the Food Stamp Act of 1977, which completely revamped the Food Stamp Program's operation. Since then, Congress has enacted amendments intended to improve the food stamp system and strengthen its integrity.

Eligible applicants receive food stamps in amounts determined by household size and income to buy food through normal market channels, primarily in authorized grocery stores. The stamps are forwarded by the grocery stores to commercial banks for cash or credit. The stamps then flow through the banking system to the Federal Reserve Bank where they are redeemed out of a special account maintained by the U.S. Treasury Department. The Food Stamp Program serves as an income security program by supplementing family income. It also contributes to farm and retail food sales and helps reduce surplus stocks by encouraging increased food purchases.

Recent studies, confirming a correlation between nutritional status and health, particularly to the elderly and children, underscore the tremendous importance of the Food Stamp Program. The program has some special rules for the elderly—including more liberal treatment of shelter costs, medical expenses, and assets. The program, for example, recognizes that elderly people with high medical bills may have total incomes higher than the poverty line, but no more money actually available for food than those with lower incomes and no medical bills. For the 15 percent of the elderly that took the medical deduction for the elderly and disabled, the average deduction was $76 per month.

Although 20 percent of food stamp households have at least one elderly member (age 60 or older), they make up only 8 percent of all food stamp recipients and receive 8 percent of food stamp benefits (an average of $31 per month) because of the typical small size of elderly households (an average of 1.5 persons) and relatively higher income compared to other recipient households of the same size. Thirty-one percent of the elderly who receive food stamps receive only the minimum benefit of $10 a month. Ninety percent of all elderly participants live alone or with one other person, usually elderly as well. Seventy percent live alone, of which 84 percent are single elderly females. More than 13 percent of elderly households also include children. Eighty-nine percent of elderly recipients have assets of $500 or less, with an average of $154 per household.

The Federal Government pays 100 percent of all food stamp benefits and 50 percent of most State and local administrative costs. State and local costs for expanding computer capability and fraud control activities are eligible for 75 percent Federal funding. The Food and Nutrition Service of the Department of Agriculture is responsible for administering and supervising the Food Stamp Program and for developing program policies and regulations. At State and local levels, the Food Stamp Program is administered by State welfare departments.

Uniform national household eligibility standards for program participation are established by the Secretary of Agriculture. All households must meet a liquid assets test and, except for those with an elderly or disabled member, a two-tiered income test to be eligible for benefits. Recipients of two primary Federal-State categorical cash welfare programs—AFDC and SSI—automatically are eligible for food stamps, although in California and Wisconsin increased SSI benefits replace food stamp assistance. The household's monthly gross income must not exceed 130 percent of the income poverty levels set annually by the Office of Management and Budget (OMB), and its monthly income (after deducting amounts for such things as medical and dependent care, shelter, utilities, and work-related expenses) must be equal to or less than 100 percent of the OMB poverty level.

To be eligible, a household cannot have liquid assets exceeding $2,000, or $3,000 if the household has an elderly or disabled member. The value of a residence, personal property and household belongings, business assets, burial plots, threshold amount for an automobile, and certain other resources are excluded from the liquid assets limit.

Certain able-bodied adult (older than 16–18, depending on their school and family status) household members who are not working must register for employment and accept a suitable job if offered in order to maintain eligibility. States are required to operate work and training programs under which adults registered to work and not exempted must fulfill State work program requirements. These may include workfare obligations, supervised job search requirements, participation in a training program, or other employment or training activities designed by the State.

Applicant households certified as eligible are entitled to a specific level of benefits—generally in the form of food coupons, which are accepted by authorized grocery stores in exchange for food. A food stamp household is expected to spend 30 percent of its cash income for food with the food stamp benefit making up the difference to buy an adequate low-cost diet based on USDA's Thrifty Food Plan, which determines the benefit level. In fiscal year 1990, the maximum food stamp benefit is $99 a month for a one-person household and $182 for a two-person household. Monthly benefits in 1989 averaged $52 per person and over $130 per household although the average was significantly lower for the elderly.

B. ISSUES

As noted above, no major food stamp legislation was enacted in the first session of the 101st Congress. However, many on Capitol Hill are already looking ahead to the 1990 reauthorization of the Food Stamp Program. Although next year's reauthorization process will likely touch upon several controversial issues, policymakers will undoubtedly visit two longstanding debates surrounding the Food Stamp Program. The first debate is simply whether the Food Stamp Program ought to be expanded. Framing this debate are alternative assumptions about the extent of hunger in the United

States and the efficacy of food stamps in combating it. The second debate concerns the determination of an appropriate Federal mechanism for assuring that States accurately dispense food stamp benefits. In anticipation of the 1990 reauthorization, it is important to review the history and basic elements of these two recurring debates.

1. The Program Expansion Debate

Hunger in America captured public attention soon after a visit to the rural South in April 1967, by members of the Senate Subcommittee on Employment, Manpower and Poverty. The subcommittee held hearings on the effectiveness of the so-called war on poverty and was told of widespread hunger and poverty. Later that year, a team of physicians found severe nutritional problems in various areas of the country. These and other reports of hunger and malnutrition in America led to an expansion of Federal food assistance programs. In 1977, physicians returned to evaluate progress made in combating hunger in these same communities and found dramatic improvements in the nutritional status of their residents. These gains were attributed to the expansion of Federal food programs in the 1970's.

Throughout the 1980's, considerable attention has focused on the re-emergence of widespread hunger in the United States. Since 1981, at least 32 national and 43 State and local studies on hunger have been published by a variety of government agencies, universities, and religious and policy organizations. They all suggest that hunger in America is widespread and entrenched, despite national economic growth.

In 1981, news accounts of bread lines and crowded soup kitchens began to appear in papers in various cities around the country. In 1982, the U.S. Conference of Mayors reported that in most cities surveyed, the need for food represented a serious emergency. In 1983, the Conference issued a report which detailed a dramatic increase in requests for emergency food assistance with unemployment cited as a primary cause.

Closely following that report, the General Accounting Office found significant increases in the number of persons seeking food assistance during the past few years, including substantial numbers of persons who recently had been financially stable. In 1983, Senator Edward Kennedy issued to the Senate Committee on Labor and Human Resources a report based on a field investigation undertaken the week before Thanksgiving 1983. Senator Kennedy found that hunger was on the rise in America and that Congress must act to improve assistance to the hungry.

The Center on Budget and Policy Priorities surveyed private nonprofit agencies which operate emergency food programs across the Nation and reported in 1983 that more than half of the 181 programs surveyed increased the number of free meals or food baskets they provided by 50 percent or more from 1982 to 1983. Nearly one-third of the programs also doubled in size over that time.

Later that year, President Reagan appointed a commission to investigate allegations of rampant hunger in the United States. At the end of 1984, the President's Task Force of Food Assistance concluded in its report that there was little evidence of widespread hunger in the United States and that reductions in Federal spending for food assistance had not injured the poor. Several modest recommendations to make the Food Stamp Program more accessible to the hungry were outlined in the report, including:

(1) Raising asset limits,

(2) Increasing the food stamp benefit to 100 percent of the Thrifty Food Plan,

(3) Categorical eligibility for AFDC and SSI households,

(4) Targeted benefit increases to beneficiaries with high medical or shelter expenses (particularly the elderly and disabled), and

(5) Modification of the permanent residence requirement so benefits are available to the homeless. These liberalizations, however, were offset by cost-reduction measures which included increasing the State responsibility for erroneous payments and an optional State block grant for food assistance.

The Food Research and Action Center (FRAC) also surveyed nationally the use of emergency food programs during the early 1980's. In 1983, FRAC found that food stamp recipients were the majority users of emergency food programs, mostly because they ran out of stamps by the second or third week of the month. It was reported that those who did not receive food stamps either did not know they were eligible, had applied and had been turned down, or did not know how or where to apply. FRAC also reported that between 1983 and 1984, there was an average monthly increase of 20.4 percent in the number of households served nationally by emergency food providers and a 17 percent per month increase between 1984 and 1985. As a result of budget cuts and changes in the law, FRAC concluded that the Food Stamp Program was neither assisting the eligible poor in an adequate fashion nor reaching the population most at risk of hunger.

The Harvard School of Public Health, after 15 months of research into the problem of hunger in New England, concluded in 1984 that:

(1) Substantial hunger exists in every State in the region,

(2) Hunger is far more widespread than generally has been realized, and

(3) Hunger in the region had been growing at a steady pace for at least 3 years and was not diminishing.

The researchers found that greater numbers of elderly persons were using emergency food programs and that many were suffering quietly in the privacy of their homes. The staff also expressed concern over what had been noted in clinical practices: Increasing numbers of malnourished children and greater hunger among their patients, including the elderly. The staff also cited the impact of malnutrition on health and stated that children and elderly people are likely to suffer the greatest harm when food is inadequate.

The Physicians Task Force on Hunger in America, established in 1984, has issued periodic reports on the nature and scope of the hunger problem, including regional and group variations. Through the Harvard School of Public Health, it also has assessed the health effects of hunger and made recommendations to remedy the problem. The group's 1984 report concluded: (1) That hunger was reaching epidemic proportions across the Nation, (2) that hunger was worsening, and (3) that increasing hunger could be attributed to Federal policies. The report estimated that up to 20 million Americans may be hungry at least some period of time each month.

In 1986, the Task Force identified 150 "hunger counties" in the United States with high poverty levels and low food stamp participation. A high concentration of "hunger counties" was identified in the Midwest and North Central States. The report concluded that the level of participation in the Food Stamp Program appeared to be related to a county's effort to enroll the poor in the program rather than a high poverty rate in the country.

Later that year, the Task Force issued another report about barriers to participation in the Food Stamp Program to determine why food stamp coverage was declining when hunger was increasing. It concluded that, while poverty had increased between 1980 and 1985, food stamp participation by those eligible had decreased because of conscious Federal policy changes that resulted in barriers to food stamp participation and limited State and local food stamp programs from reaching more needy people. Many recommendations were made to provide outreach, increase access, and liberalize the program.

In 1987, the Physician Task Force on Hunger issued a report which noted that, despite 5 years of economic growth, hunger had not been reduced significantly. More people are living in poverty, many of them the working poor and the long-term unemployed, the report found. The Task Force cited a strong downward pressure on wages, with the share of after-tax household income dropping for every income category since 1980 except the highest 20 percent. Furthermore, new persons were entering the hunger ranks, including former oil workers in the South, farm families in the Midwest, and service workers of California as well as miners and steelworkers. The report also noted the several factors that may contribute to increased hunger: (1) 25 percent of the population lives at the poverty level at some time during the year, (2) the income gap between rich and poor families had reached its widest point in four decades, and (3) Government programs designed to assist the poor have less impact than in 1979.

A study released in 1986 by Public Voice for Food and Health Policy found that the rural poor were less likely to consume adequate levels of nutrients than were the nonpoor and that rural poor children experienced stunted growth at an alarming rate. Low birth weights and high infant mortality rates were found to be significantly higher in poor rural counties than in the rest of the Nation. Also, according to 1983 data, while the highest percentage of the elderly population who live in poverty live in rural areas, only 31 percent of these rural poor elderly households receive food stamp benefits. The study also concluded that the rural poor were significantly less likely to participate in most assistance programs.

According to medical experts on aging, malnutrition may account for a substantially greater portion of illness among elderly Americans than long has been assumed. The concern about malnutrition is rising fast as the numbers of elderly climb and as surveys reveal how poorly millions of them eat. The New York Times reported in 1985 that scientists estimate that from 15 percent to 50 percent of Americans over the age of 65 consume too few calories, proteins, or essential vitamins and minerals for good health. According to the article, gerontologists are becoming alarmed by evidence that malnourishment may cause much of the physiological decline in disease resistance seen in elderly patients—a weakening in immunological defenses that commonly has been blamed on the aging process. Experts say that many elderly fall into a spiral of undereating, illness, physical inactivity, and depression. The recent findings suggest that much illness among the elderly could be prevented through more aggressive nutritional aid. In the view of some physicians, immunological studies hold out the promise that many individuals can lighten the disease burden of old age by eating better. And being poor greatly exacerbates the effect of nutrition problems. Low participation in the Food Stamp Program leaves large numbers of Americans without enough to eat and the problems exist largely because many people who are eligible for food stamps are not receiving them.

A 1987 National Survey of Nutritional Risk Among the Elderly by the Food Research and Action Center found that 18 percent of the low-income elderly who responded said they did not have enough money to buy the food they needed, 35 percent usually ate less than three meals a day, and 5.4 percent were without food for more than 3 days in the last month. Yet about a third of this sample seldom or never participated in congregate meals programs and only about 25 percent participated in the Food Stamp Program.

A 1985 report by the General Accounting Office (GAO), based on research conducted by private organizations and the USDA as well as the President's Task Force on Food Assistance concluded that nonparticipation in the Food Stamp Program by many low-income households were attributable to many factors. They include:

(1) A lack of information regarding eligibility,

(2) Relatively low benefit payments may provide little incentive for eligible elderly to apply,

(3) Administrative requirements such as complex application forms and required documentation,

(4) Physical access problems such as transportation or the physical condition of the potentially eligible applicant, and

(5) Attitudinal factors, such as households being sensitive to the social stigma associated with receiving food assistance.

One 1982 study estimated that only 50 percent of eligible elderly in the United States participate in the Food Stamp Program. Participation was very low among elderly people living alone, and the older people are, the less likely they are to participate. A lack of information about eligibility seems to be a key factor; 33 percent of eligible nonparticipants did not think they were eligible for food stamps and another 36 percent said they did not know whether they were eligible.

A November 1988 study by the Congressional Budget Office reiterates the low rate of participation in the Food Stamp Program by those eligible. According to the latest available census data, only 41 percent of eligible households and 51 percent of eligible individuals received food stamps in 1984. Eligibility conditions were, however, more strict at that time. Participation levels were the highest for lowest income households and individuals who are also eligible for higher benefits. Participation rates ranged from 67 to 90 percent for those who would receive benefits over $100 per month. Eligible families with children also had higher participation rates as many also participated in AFDC. Households with elderly members had lower participation rates of 34 to 44 percent. But the lowest participation rates were for households without children or elderly members.

Studies released by the GAO, in July and October of 1988, examined data and analyzed nonparticipation, including administrative barriers, in the Food Stamp Program. Lack of information about the program or problems with administrative practices were given as the most common reasons for not taking advantage of the program. GAO examined eight studies, all of which found that the likelihood of a household participating in the Food Stamp Program decreases as the age of the household head increases, or as the number of people aged 65 or older in the household increase. Administrative procedures which discouraged participation included limited office hours and restricted interviewing schedules, requiring households to complete screening forms before filling out food stamp applications or being interviewed, not considering applicants for expedited benefits and not helping applicants get all of the documents they need to complete their applications.

In 1989, USDA's Food and Nutrition Service released two studies examing Food Stamp Program participation rates. USDA found that participation rates were not as low as some earlier studies had suggested. Nevertheless, it concluded that some vulnerable populations, including the elderly, experience very low participation rates. USDA findings included the following: (1) 66 percent of eligible individuals and 60 percent of eligible households participated in the Food Stamp Program in 1984; (2) participating households received 80 percent of all benefits that would have been paid, if all eligible households had participated; (3) 74–82 percent of eligible persons who had income at or below the poverty line were participating in the Food Stamp Program; and (4) only 33 percent of eligible elderly individuals participated in the Food Stamp Program.

Critics of the adequacy of the Food Stamp Program have made a number of recommendations for improvement and expansion of the program, many of which have been incrementally enacted into law. They cite that the Food Stamp Program had been subject to substantial budget reductions through Congressional budget cuts and administrative changes designed to limit abuse of the program. Overall, the CBO has estimated that legislative measures taken in 1981 and 1982 held food stamp spending for fiscal years 1982–85 nearly $7 billion below what would have been spent under pre-1981 law. This translated into a 13-percent reduction at a time when poverty was at its highest level in nearly two decades. For most recipients, the changes did not lead to a direct reduction in benefits, but simply delayed or lowered benefit increases scheduled under previous law. About 1 million people, however, lost eligibility for food stamps due to changes in the law and some recipients received reduced benefits due to administrative changes.

Opponents of Food Stamp Program expansion question the accuracy of many recent hunger studies and challenge the claim that Federal program reductions have increased hunger in America. They maintain that Federal food assistance programs have been expanded in recent years, that benefits are available to any eligible person, and generally are inflation-indexed and protected from budget reductions. Critics of proposals for expansion also argue that the Federal budget deficit is a limiting factor and that the loosening of eligibility and other limits might undermine program integrity.

Proposal to improve access are the most common recommendations for expansion of the Food Stamp Program. These include increased funding, easing procedures for applying for and receiving benefits, and expanding participation through outreach and other activities. Others argue that food stamp benefits are not sufficient and should be expanded through an increased allotment or adjustments in deduction levels. Other proposals include easing eligibility rules for assets and household makeup.

2. QUALITY CONTROL AND FISCAL SANCTIONS

As do other public benefit programs, the Food Stamp Program has a quality control review system. Established by the Food Stamp Act of 1977, it requires States, with Federal oversight, to monitor their programs to identify and measure incorrect food stamp eligibility determinations and issuances. Errors may range from fraud, obtaining insufficient information, or simple arithmetic mistakes. Cases may include issuing to many or too few food stamps or improperly denying eligibility.

Beginning in fiscal year 1981, a system of monetary sanctions was put in place to create a financial incentive for States to improve program administration. Amendments passed by Congress in 1982 required States to progressively reduce their error rates (for overpayments and payments to ineligible households) to avoid sanctions. Beginning in fiscal year 1985, States must keep their error rates at 5 percent or below to avoid sanctions. However, almost all States have failed to meet targets for error reduction and sanctions assessed by the Federal Government have risen precipitously to a total of about $650 million by November 1988. Most recent estimates place the average "error rate" at 8 percent nationwide which would result in more than $800 million in erroneous payments. This is a one-third improvement over the 11.8 percent average error rate of late 1976.

Few of these sanctions have been collected, as they have been challenged by the States through administrative appeals and the Federal courts. States and other critics have found problems with the statistical soundness and other factors that affect the error monitoring system and the amount of assessed sanctions. The Administration, on the other hand, views the current sanction system as too weak, and continuously makes proposals to increase sanctions and hasten collections.

Congress responded to the States' criticisms of the quality control program by mandating two studies of the system in 1985 (P.L. 99-198), one by the USDA and the other by the National Academy of

Sciences. The same law also put a moratorium on the collection of sanctions through June 1986.

The two studies of the food stamp quality control system were released in the spring of 1987. The USDA found its system basically sound in its implementation and statistical methodology, but indicated that some improvements might be acceptable. On the other hand, the National Academy of Sciences study found significant problems, recommended a major overhaul of the system and called for the recalculation and lowering of sanctions already assessed to the States.

Studies of the food stamp quality control system by the GAO also have been critical of the program. Two 1987 reports focused on an evaluation of the system's treatment of improper eligibility terminations and denials. The study found that the States have not focused closely enough on the part of the quality control system intended to measure effectiveness in assuring that eligible households are not denied erroneously or terminated from food stamp benefits with the result that the number of these households are seriously underreported. Some of the States responded that this could be attributed to States being held liable for overpayments but not for improper denials or terminations. The USDA acknowledged that it has emphasized overissuance determinations as opposed to determinations of improper denials or terminations, and has agreed to look into the feasibility of combining error rates and a sanction system for improper denial or termination error rates.

As a result of the studies, congressional hearings and other information, corrective legislative and regulatory action for the food stamp quality control system were undertaken. The major issues addressed were:

(1) Sanctions already assessed but not yet collected,

(2) Revision of the methodology for collecting future sanctions,

(3) Whether the 5 percent tolerance level floor should be changed,

(4) Whether and how statistical methods should be revised,

(5) Whether and how to expand the system to cover other measures of program quality beyond overpayments, and

(6) Whether and how the administrative appeals process might be revised into a speedier process.

Of course, underlying any decisons for improving the quality control program are broader questions of balancing incentives for accurate and effective State administration versus a realistic appraisal of the States' actual ability to achieve certain performance standards.

C. LEGISLATION

1. Fiscal Year 1990 Appropriations

Under the Agriculture appropriations bill for fiscal year 1990 (H.R. 2883), $15.7 billion was appropriated for the Food Stamp Program, including $937 million in nutrition assistance for Puerto Rico. The House Committee on Appropriations' version of the fiscal year 1990 appropriations for the Agriculture Department included

$14.2 billion for food stamp. The Senate Appropriations Committee, in its version of the fiscal year 1990 Agriculture appropriations measure, included $15.4 billion for the Food Stamp Program. The Congressional Budget Office had projected program costs for 1990 to be $15.7 billion. Spending for food stamp benefits and the Federal share of State administrative costs is protected from sequestration under the Gramm-Rudman-Hollings deficit-reduction bill.

2. 1989 Legislation

In 1989, Congress passed two minor pieces of Food Stamp legislation, neither of which directly affected the elderly. First, Congress extended through 1990 an existing provision that increases food stamp benefits for households residing in welfare hotels (S. 1793). Second, the State of Minnesota was authorized to operate a demonstration project that permits a small number of AFDC recipients to "cash out" their food coupons (S. 1960).

D. REGULATORY AND JUDICIAL ACTION

There were no major regulatory or judicial decisions under the Food Stamp Program in 1989.

Of continuing interest, however, is the 1988 Supreme Court decision in the *United Auto Workers and United Mine Workers* v. *Lyng*. This case challenged the food stamp rule that renders an entire household ineligible for food stamps if the household contains a member who is on strike. USDA challenged a lower court decision which held in favor of the unions. The Supreme Court overturned the lower court decision, holding that the striker rule did not violate the equal protection clause or the freedom of family association.

E. PROGNOSIS

During next year's reauthorization of the farm bill, the Food Stamp Program may undergo some significant modifications. It is impossible to predict what changes may occur, but the following issues are likely to be raised:

(1) Whether food stamp benefits, particularly the minimum monthly allotment, should be increased;

(2) Whether outreach programs should be authorized in order to raise beneficiary participation rates;

(3) What steps should be taken to reduce structural barriers to potential beneficiaries' participation in the Food Stamp Program (e.g., permitting States to issue coupons by mail); and

(4) Whether the food stamp quality control programs should be altered.

In sum, 1990 could prove to be a very important year for all persons and organizations interested in the Food Stamp Program.

Chapter 7

HEALTH CARE

OVERVIEW

As it did during the 100th Congress, debate on the Medicare Catastrophic Coverage Act (MCCA) largely dominated health care policy discussions in 1989. Following the enactment of MCCA, many in Congress were surprised by the vocal and extremely negative response to the new law and its "surtax" financing mechanism. By early 1989, however, it was clear that the Congress was going to respond in some way to the discontent with the law. Debate on the appropriate response dominated discussion and action on health care legislation.

Despite months of attempts by numerous Members of Congress to save as many new benefits as possible while reducing or eliminating the unpopular surtax, the Congress concluded the only acceptable response was to repeal the new law. After only 16 months of existence, the MCCA's only remaining benefits were its Medicaid expansions; all Medicare benefits were repealed.

The Omnibus Budget Reconciliation Act of 1989, the primary vehicle for health care legislation, had a similar fate. After months of work, but prior to its final passage, the budget bill was stripped of many provisions viewed as extraneous. Many of these so-called extraneous provisions were health care provisions of significance to older Americans.

In spite of these setbacks, the Congress was able to make some significant progress in health care policy. Most notable are physician payment reform and a major rural health care initiative. Physician payment reform was a response to the rapidly increasing Medicare Part B physician reimbursement costs. The rural health care initiative was a response to hospital closings that were beginning to threaten access to care in rural areas.

Like every other year in the decade of the 1980's, one of the greatest challenges to the Congress in 1989 continued to be the need to rein in health care costs to help reduce substantial Federal deficits while assuring older Americans access to affordable, high quality health care. Every health issue affecting the elderly was framed in terms of its effects on the Federal budget.

A. MEDICARE

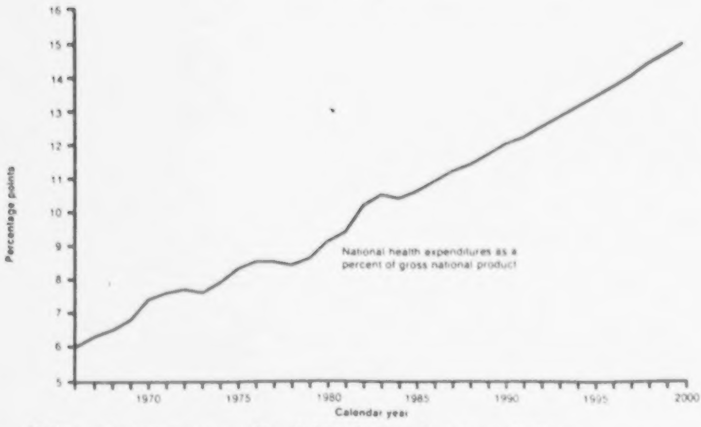
1. Background

(A) HEALTH CARE COSTS

Prior to the mid-1970's, cost of care was not a major issue among health specialists. Instead, expansion of access and the improvement of quality of care were foremost on the Nation's health policy agenda. As costs began to skyrocket, however, policymakers began to realize that controlling these increases had to become a priority, and much more attention was focused on the type of "bang" the Nation was getting for its bucks. Between 1965 and 1987, national health expenditures increased from nearly $41.9 billion (5.9 percent of GNP) to $500.3 billion (11.1 percent of GNP.)[1] (See chart 1.)

CHART 1

Percent change in national health expenditures as a percent of gross national product: Calendar years 1966-86 and projections 1987-2000



SOURCE: Health Care Financing Administration, Office of the Actuary. Data from the Division of National Cost Estimates.

Even given today's apparent slower rate of increase, health care expenditures are expected to reach $647.3 billion (12 percent of GNP) by 1990, and $1.53 trillion (15 percent of GNP) by the year 2000. (See chart 2.)

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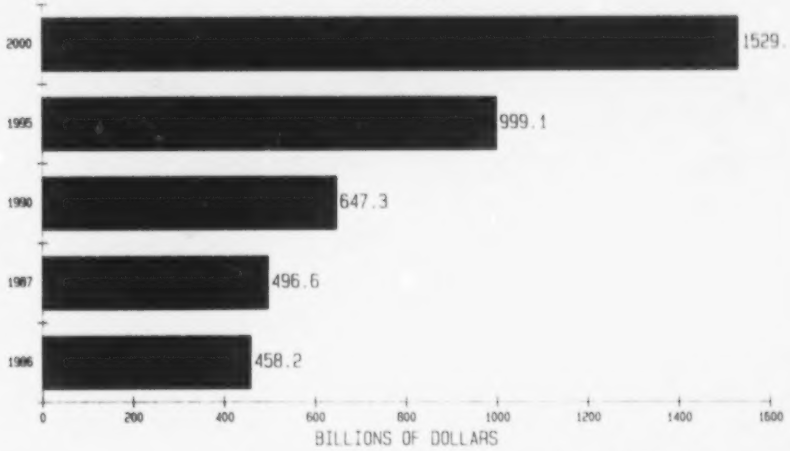
[1] DHHS, HCFA, Office of the Actuary: Data from the Office of National Cost Estimates. October 1988.

CHART 2

NATIONAL HEALTH SPENDING
1986-2000

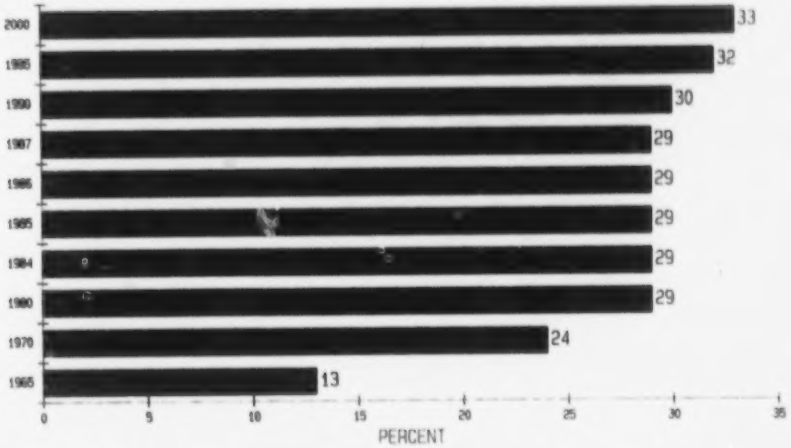


Source: National Health Expenditures, 1986-2000, Health Care Financing Review, Summer, 1987

The role of the Federal Government as a payer for health services has grown along with the overall increases in health care costs. In 1965, the Federal Government paid $5.5 billion (13.2 percent) of the Nation's health bill compared with $144.7 billion (28.9 percent) of national health expenditures in 1987. The Federal Government's share of the national health bill is projected to rise to $195.5 billion (30.2 percent) in 1990, and to $498.6 billion (33 percent) by 2000. (See chart 3.)

CHART 3

FEDERAL SPENDING ON THE NATION'S HEALTH
AS A PERCENT OF ALL FEDERAL SPENDING: 1965-2000

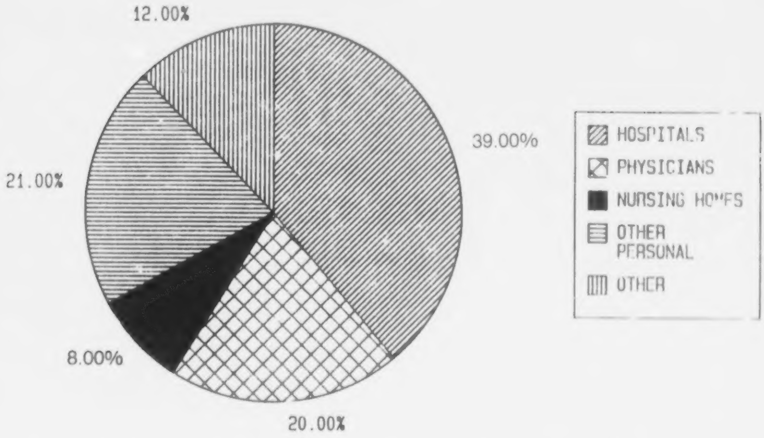


Source: National Health Expenditures, 1986-2000, Health Care Financing Review, Summer, 1987

Hospital care costs continue to be the largest component of the Nation's health care bill. In 1987, 44 percent ($194.7 billion) of the $442.6 billion spent on personal health care was paid to hospitals. During the same year, physicians were paid $103 billion or 23 percent of total personal expenditures for health care. (See chart 4.)

CHART 4

WHERE OUR HEALTH DOLLAR WENT IN 1987



Source: National Health Expenditures, 1987, Health Care Financing Review, Winter, 1988

Throughout the last two decades, the structure and delivery of health care have been plagued by perverse incentives, resulting in the over-utilization of services, inefficiency, and waste. Led by the Federal Government, which faced major funding increases each year to pay for Medicare, Medicaid, and other health programs, third-party payers began to question whether large scale reform of health care was needed. In 1983, Congress and the administration created the prospective payment system for Medicare reimbursement of hospitals, at the time the most dramatic change in Medicare since its enactment.

Prospective payment system.—The Medicare prospective payment system (PPS) pays hospitals fixed amounts that correspond to the average costs for a specific diagnosis. PPS uses a set of 477 diagnosis related groups (DRG's) to categorize patients for reimbursement. The amount a hospital received from Medicare no longer depends on the amount or type of services delivered to the patient, so there no longer are incentives to overuse services. If a hospital can treat a patient for less than the DRG amount, it can keep the savings. If the treatment for the patient costs more, the hospital must absorb the loss. Hospitals are not allowed to charge beneficiaries any difference between hospital costs and the Medicare DRG payment.

Since the 1983 Medicare PPS reform, States have moved to adopt prospective payment methodologies for their Medicaid programs. Private payers, too, are supporting a hybrid of reimbursement reforms, ranging from prospective rate setting to innovative capitation schemes. The health care arena is changing so rapidly on so many fronts that any broad characterization of it today is likely to be outdated tomorrow. Nevertheless, it seems fair to say that the overriding concern influencing the Nation's health care system is cost containment.

Trends in health care inflation.—Looked at in terms of nominal dollars (dollars not adjusted for inflation) the Nation's cost containment efforts seem to be working. In 1987, the total health care expenditures rose 9.8 percent to $500.3 billion from $455.7 billion in 1986, in nominal dollars.[2] This was the fourth consecutive annual increase in the past 20 years, that has been below the 10 percent rate of growth achieved during the economic stabilization program in 1973 when some price increases were constrained artifically.

Most analysts attribute the slowdown in the growth of health care costs to a number of factors—not simply cost containment measures alone. According to DHHS, the slowdown also has resulted from a low rate of inflation in the economy and changing patterns of demand for services, in particular a decline in the use of hospital inpatient services.

The optimistic reports on cost containment efforts aside, however, it may be possible that health care expenditures actually may be escalating faster than in the 1970's. According to Uwe Reinhardt, one of the Nation's leading health economists, Americans have been fooled into thinking that cost hikes are moderating. Reinhardt points to the fact that, "relative to the overall consumer price index, the prices of health services rose much more rapidly after 1980 than they did in the late 1970's".[3] Furthermore, the 9.8-percent increase in total health care expenditures discussed above was the highest increase in the past 4 years, while the lowest was 7.9 percent in 1985. Therefore, while the years following the initiation of PPS may show some immediate cost containment, they may not be an indication of long-term PPS cost containment.

Even more disturbing than the possibility that we have not yet harnessed spiraling health care costs is the fear that existing cost containment initiatives may be exacting a toll in other parts of the health care delivery system. Pressures to reduce costs and make health care delivery more efficient may actually reduce access to and diminish the quality of health care.

This country may, in fact, be faced with a difficult tradeoff. Given an economy struggling under huge budget deficits, the goals of "unlimited access" and "highest possible quality" are becoming more difficult to achieve. This presents Americans with the dilemma of deciding how, in a period of limited national resources, to assure access to the health care system while preserving its quality.

(B) HEALTH CARE UTILIZATION

Americans of all ages are healthier today than they were 10 to 20 years ago. While most older people report themselves to be in good to excellent health, many tend not to report specific health problems and mistakenly think they are caused by old age rather than disease. Yet age does affect a person's health, particularly the way the body reacts to disease and drugs.

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[2] HCFA, Office of the Actuary: Data from the Office of National Cost Estimates. October 1988.

[3] Uwe Reinhardt, How "Money Illusion" May Have Saved the American Health Sector from Starvation (so far), 1986.

Individual assessment of a person's own health is often the most important measure of health status and affects an individual's use of health services. Women over 65 tend to report better health than do men in the same age group.

Chronic diseases are a major threat to the independence of older persons. Arthritis, hypertension, heart conditions, and hearing disorders are leading chronic conditions among the noninstitutionalized elderly. Hospitalization of most older persons is caused by an acute episode of a chronic illness. Visits to the doctor also are most often for treatment of chronic conditions.

The dimensions of the current health services used by the elderly only hint at future needs. Health services usage by the elderly is growing because of absolute increases in the total aged population, greater numbers of individuals in the eldest subgroup, and an increased number of services provided per person. Greater expectation of good health, the availability of third-party financing and increased access to medical advances such as renal dialysis and radiation therapy also are leading reasons for greater use of health services by the elderly.

(1) Hospital Utilization

Short hospital stays by the elderly increased by more than 57 percent between 1965 and 1986. Since 1985, admissions for elderly patients decreased and then increased 0.4 percent in 1987 and 2 percent in 1988. In 1986, a survey of non-Federal short-stay hospitals revealed that 10.7 million elderly patients were discharged from hospitals, comprising 31.3 percent of all short-stay hospital patient stays. Those 75 and older accounted for 16.3 percent of short stays. According to the American Hospital Association national hospital survey, the average length of stay for elderly patients has declined, from 10.8 days in 1977 to 8.9 days in 1988.

Older persons tend to stay in the hospital approximately 50 percent longer than and twice as often as the general population. The average hospital stay for persons 65–74 was about 8.2 days in 1987 compared with 9.1 days for the 85 and older group.

(2) Use of Physicians' Services

Utilization of physicians' services increases with age. Approximately four out of five elderly living in the community had at least one contact with a physician in 1987. On average, the elderly are more likely than younger persons to make frequent visits to a physician. Persons 65 and older visit a physician nine times for every five times by the general population. Since the enactment of Medicare, the average number of physician contacts and the percentage of persons 65 and older reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.[4]

Approximately 60 percent of physician visits by the elderly are made to a doctor's office. The remaining visits are divided among hospital emergency rooms, outpatient offices, and home and telephone consultations.

The aging of the population will increase the demand for physician care. Projections show that demand will increase by 22 percent from 250 million physician contacts to 305 million contacts by the year 2000 and by 125 percent (more than 562 million visits) by 2030.[5]

Because chronic conditions are likely to increase with age, the health care needs of the elderly are broad in scope and require the participation of a number of health care professionals who specialize in geriatrics and gerontology. In addition, nurses have substantial responsibilities for providing services to the elderly in a wide range of settings such as hospitals, long-term care settings, ambulatory care programs, and day care programs. Dentists, social workers, and allied health care professionals also can actively contribute to the care of the elderly when they understand the needs of older patients. Available data, however, indicate that only a small fraction of professional health care schools have programs in geriatrics and gerontology.

(3) Use of Home Health Services

Home health care has been one of the most rapidly growing Medicare benefits. There has been rapid growth in the number of participating agencies (from 3,000 in 1981 to more than 5,700 currently) as well as the volume of visits and services provided. Growth has begun to level off as a result of efforts by HCFA to curtail growth. (See table 1.)

TABLE 1.—MEDICARE HOME HEALTH SERVICES

Year	Persons served (thousands)	Number of persons served per 1,000 enrollees	Total reimbursements (millions)	Total visits (millions)	Number of visits per 1,000 enrollees
1975	500	22	$215	11	431
1980	957	34	662	22	788
1983	1,351	45	1,398	37	1,227
1984	1,516	50	1,666	40	1,324
1985	1,589	51	1,773	40	1,279
1986	1,600	50	1,796	38	1,208

Source: HCFA.

The increase in home health utilization stems in part from legislative changes adopted in 1980 that removed certain payments, coverage, and participation restrictions from the home health benefit. Additionally, implementation of the prospective payment system in 1983, with its incentives for more efficient management of health care resources, resulted in a significant drop in hospital lengths of stay and prompted a transfer of care from inpatient hospital settings to a variety of outpatient settings, including home health agencies. The decrease in home health utilization since 1985 may, therefore, be a reflection of more stringent eligibility criteria and other administrative issues, rather than a diminishing need for care.

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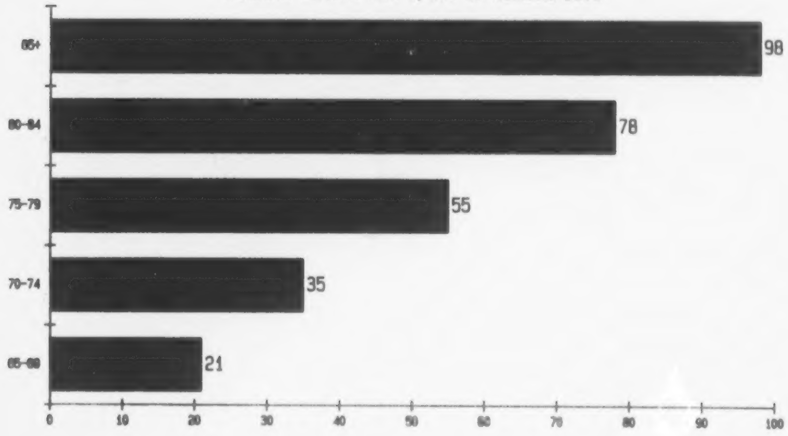
[4] U.S. Senate Special Committee on Aging, America in Transition: An Aging Society. Washington, D.C., U.S. Govt. Print. Off., 1987-88 edition, p. 117.

[5] Ibid.

The increasing lifespan, the aging of the elderly population, and the continuing advances in medical technology all suggest that more elderly Americans will suffer chronic conditions that limit their daily activities. Older Americans with chronic conditions will require extensive health care services, including home health care. It should be noted, however, that Medicare will cover only those home health services where a need for skilled nursing care or physical or speech therapy can be demonstrated. Most chronically impaired persons do not need skilled care to remain in their homes. Instead, they require nonmedical supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel. In 1986, Medicare beneficiaries over 85 were nearly four times more likely to receive home care services than Medicare beneficiaries aged 65-69. As the "old-old" population (those older than 85) increases, home care demand and utilization also will increase significantly. (See chart 5.)

CHART 5

USE OF HOME HEALTH SERVICES
PERSONS SERVED PER 1,000 ENROLLEES: 1983



Source: Marian Gornick et. al., "Twenty Years of Medicare and Medicaid," Health Care Financing Review, Annual Supplement

(4) Use of Disease Prevention Services

Utilization of disease-prevention services by the elderly varies by type of service. For example, elderly persons visit dentists less often than the younger population. In 1986, only 43 percent of those over 65 used dental care, while 59 percent of the general population did. Presently, older persons do not receive sufficient preventive or therapeutic dental care. It is estimated that almost one-third of the population is lilkely to lose some or all of their teeth between the ages of 50 and 70, primarily because of periodontal disease.

In contrast to the low incidence of dental care, 41 percent of the elderly in 1979–80 had one or more eye-care visits compared with 24 percent of those under 65. This percentage almost certainly would be higher if Medicare covered optical services and products.[6]

Many of the chronic conditions of the elderly are strongly associated with personal health habits. In general, there is only fragmented evidence that links changes in the health habits of older persons to reduced risk of disease. The most dramatic example of a behavior change that produces positive effects on health is cessation of cigarette smoking, which is a major risk in cardiovascular diseases and selected cancers. When a person of any age stops smoking, the benefits to the heart and the circulatory system begin right away. The risk of heart attack and stroke drops and circulation to the hands and feet improves. Nonsmokers also have a lower risk of contracting influenza and pneumonia, which sometimes can be life-threatening diseases for older persons.

(5) Health Care Expenditures of the Elderly

Persons 65 and older, 12 percent of the population, account for more than one-third of the Nation's total personal health care expenditures. These expenditures represent total health care investment from all sources exclusive of research. In 1987 (the latest data currently available), total personal health care expenditures for the elderly were estimated at $162 billion (tables 2 and 3) and per capita spending reached $5,360. That represented a 13.6 percent average annual growth rate since 1977. It is particularly notable that older Americans spend as large a percentage of their income on health care needs (15 percent) as they did prior to the existence of Medicare.

TABLE 2.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1984:					
Total per capita	100.00	100.00	100.00	100.00	100.00
Private	32.8	11.4	39.7	51.9	65.3
Consumer	32.4	11.0	39.6	51.2	64.8

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[6] Ibid., p. 123.

TABLE 2.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984—Continued

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
Out-of-pocket	25.2	3.1	26.1	50.1	59.9
Insurance	7.2	7.9	13.5	1.1	4.9
Other private	.4	0.4	.0	.7	.5
Government	67.2	88.6	60.3	48.1	34.7
Medicare	48.8	74.8	57.8	2.1	19.9
Medicaid	12.8	4.8	1.9	1.5	11.4
Other government	5.6	9.1	.7	4.4	3.4

TABLE 3.—DISTRIBUTION OF PER CAPITA PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY TYPE OF SERVICE AND SOURCE OF FUNDS: UNITED STATES, 1984

Year and source of funds	Total per capita	Type of service				
		Total care	Hospital	Physician	Nursing home	Other care
1984:						
Total per capita	$4,202	100.0	45.2	20.7	20.9	13.2
Private	1,379	100.0	15.7	25.0	33.1	26.2
Consumer	1,363	100.0	15.3	25.3	33.1	26.3
Out-of-pocket	1,059	100.0	5.6	21.4	41.6	31.3
Insurance	304	100.0	49.2	38.6	3.3	8.9
Other private	16	100.0	42.1	1.9	39.1	17.0
Government	2,823	100.0	59.7	18.6	15.0	6.8
Medicare	2,051	100.0	69.2	24.5	.9	5.4
Medicaid	536	100.0	17.0	3.1	68.1	11.8
Other government	236	100.0	73.2	2.4	16.5	7.9

Source: Waldo, Daniel R., Lazenby, Helen C.; Demographic Characteristics and Health Care Use and Expenditures by the Aged in United States: 1977–84, "Health Care Financial Review," vol. 6, No. I, fall 1984.

(6) Health Care Expenditures by Source

(a) Hospital

Hospital care for the aged cost $68 billion in 1987; this is an amount equal to $2,248 per capita. Medicare will reimburse about 70 percent of that total while other public funds will pay about 15 percent of the bill. Private health insurance will cover the remaining 15 percent.

(b) Physicians' services

Spending for physician services to the elderly grew an average of 16 percent per year from 1977 to 1987, reaching a level of $33.5 billion for 1987.[7] Medicare spending accounted for an estimated 57.8 percent of the per capita expenditures (for the aged) for physician services in 1984 ($504 out of a total $868). During the period from 1980–83, Medicare physician expenditures increased (adjusted for inflation) at an average annual rate of 12 percent, compared to 6.5

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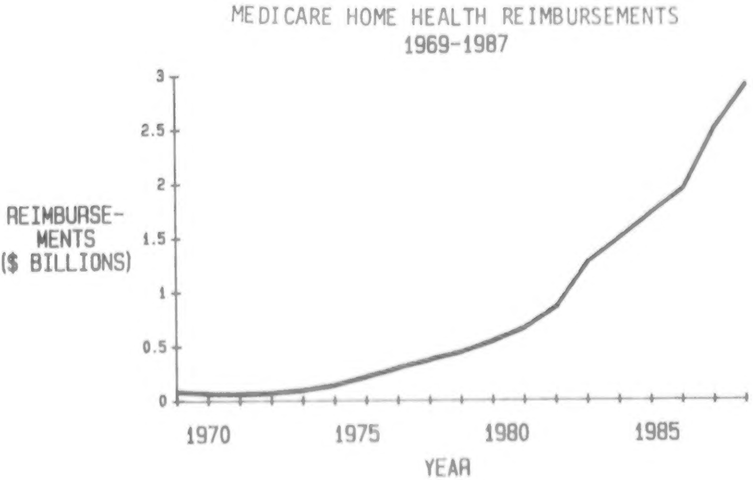
[7] Waldo, Daniel R., et al. Health Expenditures by Age Group, 1977 and 1987. Health Care Financing Review. Vol. 10, No. 4, summer, 1989, page 114.

percent for all physician expenditures. From 1983 to 1986, expenditures increased at an average annual rate of 9.1 percent and 7.2 percent, respectively.[8] The different rates of increase in expenditures suggest that Medicare beneficiaries receive a higher volume of physician services than the rest of the population. Whether this is a result of Medicare beneficiaries needing more services because of poorer health or incentives within the current reimbursement system to increase the volume of services rendered is a matter of considerable debate.

(c) Home health services

As a percentage of total Medicare expenditures, the amount of reimbursement for home health care has been small. According to HCFA, Medicare payments for home health care comprise a relatively small 3 percent of total program outlays. For fiscal year 1989, total reimbursements for Medicare home health services were projected to be $2.9 billion. Chart 6 indicates however, that Medicare's home health benefit expenditures are one of the fastest growing components of the Medicare Program.

CHART 6



Source: HCFA/Division of Budget

(C) MEDICARE PROGRAM DESCRIPTION

Medicare was enacted in 1965 to insure older Americans for the cost of acute health care. Over the past two decades, Medicare has provided millions of older Americans with access to quality hospital care and physician services at affordable costs. In 1989, Medicare insured 33 million aged and 3 million disabled individuals. At a fiscal year 1989 estimated cost of $86.9 billion, Medicare is the second most costly Federal domestic program, exceeded only by the Social Security program.

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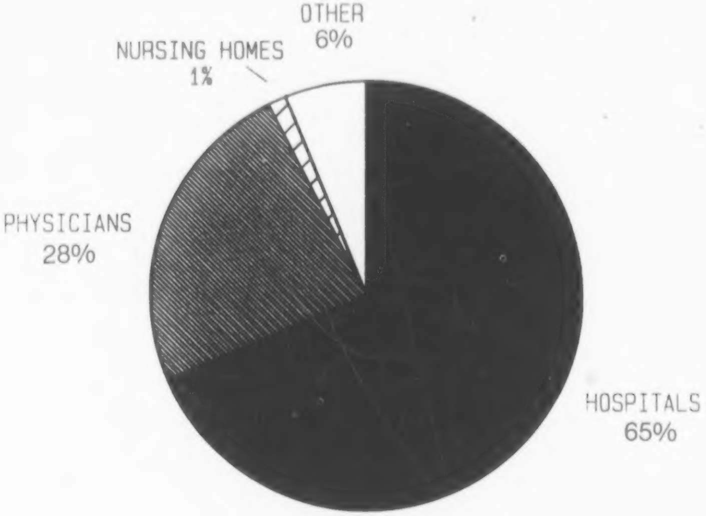
[8] Ibid., p. 112.

As insurance for short-term acute illness, Medicare covers most of the costs of hospitalization and a substantial share of the costs for physician services (see chart 7). However, until the enactment of catastrophic health care legislation, Medicare did not cover the hospital costs of extended acute illnesses and did not protect beneficiaries against potentially large copayments or charges above the Medicare payment rate for physician services. These shortcomings in Medicare's coverage of acute illness costs have led between 70 and 80 percent of older Americans to purchase supplemental private coverage, often referred to as medigap coverage.

CHART 7

WHERE THE MEDICARE DOLLAR GOES: 1985



SOURCE: Health Care Financing Administration,
Office of Financial and Actuarial Analysis, Unpublished data

Medicare (authorized under title XVIII of the Social Security Act) provides health insurance protection to most individuals 65 and older, to persons who have been entitled to Social Security or railroad retirement benefits because they are disabled, and to certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with a uniform eligibility and benefit structure throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is composed to two parts—the Hospital Insurance (HI) Program (Part A), and the Supplementary Medical Insurance (SMI) Program (Part B).

(1) Hospital Insurance Program

Part A is financed principally through a special hospital insurance payroll tax levied on employees, employers, and the self-employed. During 1989, each worker and employer paid a tax of 1.45 percent on the first $48,000 of covered employment earnings. The self-employed pays both the employer and employee shares. In 1990, each worker and employer will pay 1.45 percent on the first $51,300 of covered earnings.

In calendar year 1989, payroll taxes for the HI trust fund amounted to $65.4 billion, accounting for 87.1 percent of all HI income. Interest payments, transfers from the railroad retirement account and the general fund along with premiums paid by voluntary enrollees equaled the remaining 12.9 percent. Of the $58.2 billion in HI disbursements, $57.4 billion was for benefit payments while the remaining $800 million was spent for administrative expenses.

(a) Catastrophic health care provisions

In 1988, the benefits and, to a smaller extent, the financing, of the Medicare Program were overhauled. On July 1, 1988, President Reagan signed the MCCA into Public Law 100-360. A little over 1 year later, this law was repealed. The following are highlights of the major provisions of the MCCA as it relates to Part A of the program. Provisions retained or repealed by the Medicare Catastrophic Coverage Repeal Act of 1989 are noted. (A summary of the new Part B benefits can be found in the next section and an extensive discussion of the development and repeal of the catastrophic health care legislation can be found in the Issues and Legislative Actions section of this chapter.)

Effective date.—The new Part A benefits became effective January 1, 1989, were repealed on November 22, 1989, and eliminated on January 1, 1990.

Inpatient hospital services. (Repealed)—Specified a maximum of one hospital deductible per year ($560 in 1989) and eliminated the day limits, coinsurance charges, and spell of illness provisions.

Skilled nursing facility services. (Repealed)—Required daily coinsurance payments for the first 8 days equal to 20 percent of the national average Medicare reasonable cost for SNF care (estimated at $20.50/day in 1989); eliminated coinsurance charge for 21st-100th days; added coverage for up to 150 days and eliminated prior hospitalization requirement.

Home health services. (Repealed)—Expanded the "intermittent" skilled nursing care definition for the Home Health benefit so that "daily" care could be reimbursed by Medicare for up to 7 days a week, or a total of 38 days (instead of 5 days a week for up to 2 or 3 weeks).

Hospice services. (Repealed)—Under this benefit, a beneficiary was able to elect to receive services for two 90-day periods and one subsequent 30-day period during his or her lifetime. The MCCA provided for a subsequent extension period beyond the current 210-day limit, if the beneficiary was recertified as terminally ill.

(2) Supplementary Medical Insurance

Part B of Medicare, also called supplementary medical insurance, is a voluntary, nonmeans-tested program. Anyone eligible for Part A and anyone over age 65 can obtain Part B coverage by paying a monthly premium ($27.90 in 1989 and $29 in 1990). Part B covers physicians' services, outpatient hospital services, physical therapy, diagnostic and X-ray services, durable medical equipment and certain other services. Part B is financed by a combination of beneficiary premiums, deductibles, copayments, general revenues, and Part B trust fund interest. Under current law, premiums must cover 25 percent of program costs (i.e., actual program outlays); the remaining 75 percent are funded from general revenues.

In 1988, approximately 31.7 million people were covered under Part B. General revenue contributions totaled $26.2 billion, accounting for 74 percent of all income. Another 24.5 percent of all income was derived from premiums paid by participants, with interest payments accounting for the remaining 2.4 percent. Of the $35.2 billion in disbursements, $34 billion (94 percent) was for benefit payments while the remaining $1.2 billion (3.6 percent) was for administrative expenses.

(a) Physician reimbursement

Medicare pays physicians the "reasonable" or "approved" charge rate for their services, less the deductible and the copayment. The reasonable charge levels for a service have been determined through a method referred to as customary, prevailing, and reasonable (CPR). Under CPR, payment for each service is limited to the lowest of: (1) The physician's actual bill for the service; (2) the physician's customary charge for the service, or (3) the prevailing charge for the service in that community. (Increases in the prevailing charge are limited by the Medicare economic index.) To control ever-increasing Part B program expenditures and to provide beneficiaries with the opportunity to select a physician who has agreed to accept Medicare's "assigned" rate, the Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369) established the concept of the participating physician. A participating physician voluntarily enters into an agreement with the Secretary of the Department of Health and Human Services to accept assignment (Medicare's allowable reimbursement rate) for all services provided to all Medicare patients for a 12-month period. If assignment is accepted, beneficiaries are not liable for any out-of-pocket costs other than standard deductible and coinsurance payments.

A number of incentives have been implemented to encourage physicians to sign participation agreements. These include higher prevailing charge screens, more rapid claims payment, and widespread distribution of participating physician directories. In 1989, 40.7 percent of doctors were participating physicians.

To ensure that limitations on Medicare payments do not result in higher out-of-pocket costs for beneficiaries, the Omnibus Budget Reconciliation Act of 1986 (OBRA, P.L. 99-509) established maximum allowable charge limits (MAACs) which limit the actual charges of nonparticipating physicians during the 4-year period beginning on January 1, 1987. Under the MAAC limits, nonparticipating physicians with actual charges in excess of 115 percent of the prevailing charge are limited to a 1 percent annual increase in their actual charges. Nonparticipating physicians with lower actual charges may increase their charges at a more rapid rate so that in the fourth year their charges will equal 115 percent of the prevailing charge.

The Omnibus Reconciliation Act of 1989 made substantial changes in the way Medicare will pay physicians. The legislation provides for the establishment of a fee schedule based on a relative value scale (RVS). An RVS is a method of valuing individual services in relationship to each other. The RVS is coupled with annual volume performance standards which are target rates of increase in physician expenditures. Physician payment reform is discussed in depth later in this chapter.

(b) Catastrophic health care provisions

The MCCA made extensive revisions to the Part B benefit. The Catastrophic Coverage Repeal Act of 1989 (P.L. 101-234), repealed most of the revisions. The benefit changes, as well as the new law's financing mechanism, are summarized below. Provisions retained or repealed by the Congress in 1989 are noted.

Effective date.—The start-up date for implementation of these new benefits was January 1, 1989. They were repealed by the Congress on November 22, 1989 and were eliminated effective on January 1, 1990.

Limitation on out-of-pocket expenses. (Repealed)—Established a maximum out-of-pocket limit (the "catastrophic cap") on beneficiary liability for Part B cost-sharing charges after which Medicare will pay 100 percent of the approved amount. The limit was set at $1,370 in 1990; it was indexed so that a constant 7 percent of beneficiaries would be eligible for this catastrophic benefit each year.

Prescription drugs. (Repealed)—Established, effective January 1, 1990, a limited prescription drug benefit for home intravenous (IV) drugs and immunosuppressive drugs furnished after the first year following a transplant (they are already covered in the first year). The deductible was $550 in 1990; the coinsurance was 20 percent for home IV drugs and 50 percent immunosuppressives. Provides coverage, beginning January 1, 1991, for all outpatient prescription drugs, subject to a $600 deductible and 50 percent coinsurance charges. The deductible was slated to go to $652 in 1992 and be indexed in future years so that 16.8 percent of beneficiaries would reach the deductible each year. The coinsurance was slated to be lowered to 40 percent in 1992 and 20 percent in 1993.

Medigap policies. (Amended to reflect repeal of catastrophic coverage)—Amended procedures for Federal certification of medigap policies. Applied the National Association of Insurance Commissioners (NAIC) revision of medigap minimum standards for purposes of Federal certification. Policies sold before enactment, but still in effect on January 1, 1989, were not to be deemed to duplicate Medicare's new benefits if they comply with the NAIC model transition rule which provides for refunds, or premium adjustments, when appropriate, for duplicable portions. Required a one-time notice to be sent to policyholders by January 1, 1989, on the new benefits, how they affect the policy's benefits and premiums, and any adjustments that will be made.

Federal employees. (Repealed)—Required the Director of the OPM to reduce, effective January 1, 1989, the rates charged to Medicare-eligible individuals participating in the Federal Employee Health Benefits Program (FEHBP) to reflect the amounts that would have been paid by those plans designed specifically for Medicare-eligible individuals. (See also supplemental premium below.)

Maintenance of effort. (Repealed)—Under this benefit, any employer who provided health benefits to an employee or retired former employee (including State and local employees) that duplicated at least 50 percent of the new or improved Part A and Part B benefits would have to provide additional benefits or refunds that total at least the actuarial value of the duplicative benefits. The provision was effective with respect to Part A benefits in 1989 and was to be effective with respect to Part B benefits in 1990 except that an extension was provided to cover current collective bargaining agreements.

Medicaid. (Retained)—Mandated States, on a phased-in basis, to pay Medicare premiums, deductibles, and coinsurance for elderly and disabled individuals with incomes below the poverty line. Also, in the case of a couple where one member is institutionalized, the bill provided protection of a portion of the couple's income and resources for maintenance needs of the community spouse. States must allow the community-based spouse to keep 122 percent of the Federal poverty level in income. This percentage will increase to 150 percent by 1992. See Chapter 8 for more information on asset protection.

Respite care. (Repealed)—Provided coverage for in-home care for a chronically dependent individual for up to 80 hours per year. The benefit was only available for persons who meet either the catastrophic cap or the outpatient prescription drug cap.

Mammography screening. (Repealed)—Established a new Medicare benefit. Screenings for women over 65 would be covered every other year, subject to a maximum payment per screening of $50 in 1990 (indexed in future years).

(c) Catastrophic coverage financing (Repealed)

The law was to be financed through a combination of (1) an increase in the monthly Part B premium for all Part B enrollees, and (2) a new supplemental premium which would have been mandatory for all those entitled to Part A who have Federal tax liability of $150 or more.

(4) Peer Review Organizations

Hospitals are required to enter into agreements with peer review organizations (PRO's) as a condition for receiving payments under Medicare's PPS for inpatient hospital services. PRO's review the services provided to Medicare patients to assure that services are medically necessary, provided in the appropriate setting, and meet professionally recognized standards of quality health care.

The Secretary of the DHHS is required to contract with PRO's. Organizations eligible for PRO contracts include physician-sponsored organizations, physician-access organizations, and health benefit payer organizations. PRO's are expected to serve the dual role of curtailing unnecessary costs and assuring the quality of health care. However, in recent years, Aging Committee investigations have found that PRO's primary emphasis has been on controlling costs, rather than on assuring quality care.

There are 54 PRO contract areas. Each of the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands are designated as separate PRO areas. Guam, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands are considered to be in a single PRO area. In these 54 PRO areas, DHHS has contracted with 41 PRO's to review the care provided in those areas.

The PRO review process begins after a Medicare beneficiary is discharged from the hospital and payment is made. Paid bill data is sent to the PRO, which selects a sample for review and requests the relevant medical records from the hospital. PRO reviewers (usually nurses) use criteria that contain the generally recognized reasons justifying a patient's hospital admission or surgical procedure. If the PRO reviewer determines that the care was not medically necessary or that it should have been provided in another setting (e.g., an outpatient facility), the PRO will issue a payment denial. A payment denial can only be made after the attending physician has been given an opportunity to discuss the case with a PRO physician. For the latest contract period, which began in June 1986 and continues through 1989, 2.03 percent of all reviewed discharges were denied on the basis of inappropriate admissions. To help ensure Medicare reimbursement, some States require physicians to call the PRO for pre-admission and extended stay approval.

(5) The Health Maintenance Organization Benefit

During 1982 and 1983, DHHS awarded 26 Medicare demonstration program contracts to develop Medicare Health Maintenance Organizations (HMO's). These demonstration projects, which were operational in 21 cities across the country, were implemented to test whether the HMO concept would be effective in holding down Medicare expenditures. HCFA initiated a nationwide program in 1985 providing for the expanded use of HMO's by Medicare.

Two kinds of organizations are eligible to contract with Medicare: Federally qualified HMO's under the 1973 HMO Act and competitive medical plans (CMP's) as defined in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). For Medicare purposes, the standards that these two kinds of entities must meet to participate in the program are essentially identical. The difference between them is in the way they operate in the private market. The CMP was created to broaden participation and stimulate competition in the medical marketplace.

Under TEFRA, Medicare pays participating organizatons for services rendered. HMO's signing a risk contract agree to provide all defined services at the HMO's risk. In other words, the HMO is responsible for any cost overruns. The beneficiary who enrolls in a risk-contract HMO must receive all medical services except for emergency or urgently needed services from that HMO. This feature is referred to as the "lock-in" provision. Beneficiaries must pay for services received outside of the plan or those services that have not been authorized by the HMO. Neither the HMO's nor Medicare are responsible for payment of out-of-plan services.

The formula used to determine the payment per HMO beneficiary is based on the average adjusted per capita cost (AAPCC), the fee Medicare estimates it would have paid traditional providers (hospitals and fee-for-service physicians) in the same community. HMO's receive 95 percent of the AAPCC, thereby saving Medicare 5 percent on each Medicare HMO enrollee. HMO's also are permitted to charge beneficiaries a monthly premium equal to the value of traditional Medicare deductibles and copayments. (In contrast, HMO's which contract out with Medicare under a "cost" contract are paid on a prospective basis, but are reimbursed for cost overruns.)

In January 1988, there were 1,169,684 Medicare beneficiaries enrolled in TEFRA risk or cost contracts with HMO's or CMP's. This figure represents about 3.8 percent of the total Medicare population. At that same time, 155 risk contracts and 32 cost contracts were in effect, with another 27 risk contract applications pending. (An additional 566,491 beneficiaries were enrolled in prepaid plans under arrangements other than TEFRA contracts.)

(D) SUPPLEMENTAL HEALTH INSURANCE COVERAGE

At its inception, Medicare was not designed to cover its beneficiaries' total health care expenditures. Several types of services, such as long-term care for chronic illnesses, are not covered at all, while others are partially covered and require the beneficiary to pay deductibles, copayments, and coinsurance. Medicare covers approximately half of the total medical expenses for noninstitutionalized, aged Medicare beneficiaries. Other health care expenditures remain to be covered directly out-of-pocket, with private supplemental health insurance, such as medigap, by Medicaid, and other sources.

The term "medigap" is commonly used to describe a private health insurance policy that is designed to supplement Medicare's coverage. There currently exists no survey that collects, on an ongoing basis, information about medigap coverage. Several studies, however, have been conducted over the past couple years that examine this issue, which are discussed below. In general, one can conclude from them that approximately 70 to 80 percent of those with Medicare (about 20 million persons) have some type of supplemental health insurance coverage, although not all of it is medigap. About 40 percent of those with Medicare purchase private insurance, most of which is Medicare. Another 30 or 35 percent of Medicare beneficiaries have employment-based coverage, less than one-half of which is medigap.

The Current Population Survey (CPS), conducted by the Census Bureau, collects information on other health insurance coverage held by Medicare beneficiaries. The survey does not collect information on medigap insurance specifically, but rather on any type of health insurance that a Medicare beneficiary might hold, whether purchased privately or provided by an employer. According to preliminary data from the CBO, the March 1988 CPS found that approximatley 71 percent of noninstitutionalized aged Medicare beneficiaries (19.4 million persons) had some type of private coverage in 1987. Approximately 41 percent of these beneficiaries (11.3 million) had individually purchased, nonemployment-based private coverage. It is reasonable to assume that most of this coverage is through medigap policies, although the survey does not provide this information.

The Health Insurance Association of American (HIAA) conducted a national telephone survey of 500 older Americans (age 65 and older) in April and May 1989.[9] Of those surveyed, 78 percent had some type of private insurance to supplement Medicare. However, persons who were eligible for both Medicare and Medicaid were not included in this survey, as they typically do not purchase private health insurance. If these persons had been included, the rate of policy ownership would have been lower, about 70 percent.

The National Medical Expenditure Survey (NMES) was conducted in 1987 by the National Center for Health Services Research and Health Care Technology Assessment of DHHS. Data from the first quarter of 1987 show that approximately 75 percent of the aged Medicare beneficiaries (about 20 million people) had some type of private health insurance.[10] Approximately 40 percent had privately purchased policies and 35 percent had employment-related coverage.

The HIAA survey found that there were several factors relating to the likelihood of an older person having medigap insurance. Those persons age 80 and under, whites, married, better educated, higher incomes, and those reporting better health status were all most likely to have one or more supplemental insurance policies. The differences were not great for most factors, with the exception of race: while 82 percent of whites had policies, only 33 percent of nonwhites did. Although income was not a factor above $10,000, data from CBO found that in 1984, only about 44 percent of the elderly with incomes below $5,000 had private supplemental insurance, compared to 87 percent of those with incomes of $25,000 and over.

The regulation of private insurance has traditionally been a State responsibility. However, the National Association of Insurance Commissioners (NAIC) has developed model standards which can be adopted by States. These standards specify, among other things, the minimum benefits that a policy must cover. These were adopted by NAIC in the mid-1970's, and have been amended several times since then.

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[9] Rice, Thomas, Katherine Desmond, and Jon Gabel. *Older Americans and Their Health Coverage.* Health Insurance Association of America Research Bulletin, October 1989. p. 15–20.

[10] Monheit, A., and C. Schur. *Health Insurance Coverage of Retired Persons.* National Medical Expenditure Survey Research Findings 2, National Center for Health Services Research and Health Care Technology Assessment. DHHS Publication No. (PHS) 89-3444, September 1989. p. 8–10.

Despite the NAIC model law and regulations, abuses in the sale of medigap policies persisted, leading Congress to include in the Social Security Disability Amendments (P.L. 96-265), enacted June 1980, a new Section 1882 entitled "Voluntary Certification of Medicare Supplemental Health Insurance Policies," also known as the Baucus amendment, after the chief sponsor of the amendment, Senator Max Baucus. Section 1882 established standards for medigap policies based primarily on the June 1979, NAIC model standards. It establishes loss ratio requirements for group and individual medigap policies. It also provides criminal penalties for certain abusive medigap sales practices, including making false statements and misrepresentations, and selling policies that duplicate Medicare's benefits.

The Federal medigap standards are implemented in two ways. Individual insurers may voluntarily submit their policies to the Voluntary Certification Program to be certified and authorized to display a Federal emblem if they are found to meet or exceed the minimum standards. Or, recognizing the traditional role of States in regulating insurance, States may adopt the Federal medigap standards as part of their regulatory program. If the State programs meet or exceed the Federal standards, then policies approved in those States are deemed to have met the Federal requirements, and the Voluntary Certification Program do not apply.

In December 1980, the NAIC revised its model standards to incorporate the requirements of the Baucus amendment. These model standards required policies to:

—cover all Medicare inpatient hospital coinsurance for days 61 through 90 and for the lifetime reserve days;

—cover the Part B coinsurance, which could be subject to a $200 deductible and a maximum benefit of at least $5,000 per year;

—cover 90 percent of covered charges after a beneficiary exhausted his or her hospital benefits, subject to a lifetime maximum benefit of an additional 365 days;

—not define preexisting conditions more restrictively than as a condition that was diagnosed or treated within 6 months before the policy's effective date and not deny a claim, on the basis of preexisting conditions, for services furnished more than 6 months after such effective date;

—return to policyholders in the form of aggregate benefits at least 75 percent of aggregate premiums collected for group policies and at least 60 percent of aggregate premiums collected for individual policies; and

—require that purchasers of a policy have a "free look" period, during which time they could return an unwanted policy for cancellation and receive a full refund of any premium paid.

According to a 1986 GAO study of the medigap market,[11] all but four States had adopted medigap insurance regulatory programs at least as stringent as NAIC. This has resulted in more uniform regulation of medigap insurance and increased protection for the elderly against substandard or overpriced policies. Most large commercial insurers, with premiums of $50 million or more, met the loss ratio requirements of Section 1882. However, more than 60 percent of the commercial insurance policies with premiums under $50 million had not met those requirements. The aggregate figures for all individual policies studied by the GAO showed that about 60 cents of every premium dollar was returned as benefits or added to reserves.

Of 142 policies studied by the GAO, the loss ratios of most policies were below the Section 1882 targets. However, the loss ratios of both Blue Cross/Blue Shield plans and Prudential Life Insurance usually were above the targets. This is important because these policies are the most frequently purchased. In 1984, the Blue Cross/Blue Shield plans had an aggregate loss ratio of 81.1 percent while the Prudential plans had a loss ratio of 77.9 percent.

While the loss ratio is a useful guideline to determine if the benefit level is adequate, it is not a requirement. Therefore, according to DHHS's interpretation of the law, States are not required to monitor loss ratio experience. Furthermore, penalties for medigap sales abuse have been seen as the prerogative of the States because they primarily are responsible for regulating the insurance industry. All States GAO visited had a formal complaint system, within either the State insurance department or the State department of elderly affairs. These States also monitored the advertising practices of insurance companies. GAO concluded that Section 1882, when combined with State efforts, not only was protecting the elderly against substandard medigap policies, but also was providing them with information on how to select medigap policies. This conclusion has been criticized by some consumer organizations, including Consumers Union, who question the compliance of medigap insurers with the spirit and intent of the law.

MCCA included a provision amending Section 1882 to require revision of the Federal minimum standards so that coverage of benefits that duplicated Medicare's new benefits would not be required. However, legislation repealing MCCA required revision of the NAIC medigap standards, this time to expand the minimum benefit requirements to complement the reduction in Medicare's benefits. In order for a policy to be certified, it has to meet the revised standards by the earlier of the date the State adopts the revised standards, or 1 year after NAIC adopts the revised standards (December 13, 1990).

NAIC approved revised standards, effective on December 13, 1989, that include new minimum benefit standards and prohibitions against certain abusive marketing practices. They must cover the following minimum benefits:

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[11] U.S. Government, GAO, Report to the Subcommittee on Health, House Committee on Ways and Means, Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies. October 1986.

—Part A Medicare eligible expenses for hospitalization not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
—either all or none of the Medicare Part A inpatient hospital deductible;
—Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;
—after exhausting all Medicare hospital inpatient benefits including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days;
—the Part A and Part B blood deductible;
—the coinsurance amount of Medicare eligible expenses under Part B (currently 20 percent) regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

Medigap premiums vary depending on the extent of benefits covered (and the allowable charges made by health care providers to provide those benefits), and other factors such as the extent of utilization of health care services by the covered population, administrative costs, insurance company profit, and reserve requirements. In addition, the cost of a plan can vary depending on the age and geographic location of the enrollee. The 1989 HIAA telephone survey mentioned above found that the mean 1989 annual medigap premium was $718 and the median was $640. However, it is important to note that 1989 medigap policies offered fewer benefits in prior or subsequent years because of the more extensive coverage offered by the MCCA.

In 1989, the staff of the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging conducted a telephone survey of officials in the State departments of insurance regarding recent medigap premium increases. The increases in the 44 States responding to the survey ranged from 10 percent to 133 percent. They also found that 73 percent of the 44 States required that medigap premium increases for individual policies be formally approved by the State before going into effect.[12]

Senator Heinz chaired a field hearing on January 8, 1990, in Harrisburg, PA, to investigate proposed medigap premium jumps of 20 to 70 percent. GAO released the findings of research undertaken at the Senator's request which basically showed seniors were provided better coverage under the Medicare catastrophic program.

In preparation for hearing testimony before the Senate Special Committee on Aging, GAO contacted 29 commercial medigap insurers to obtain their current estimate of their premium changes. As stated in the GAO testimony, 20 companies responded. The average increase in the 1990 premiums over 1989 is estimated to be 19.5 percent, or $11.44 per month. The increases ranged from 5 percent to 51.6 percent. The average monthly premium in 1989 was $58.52 ($702.24 per year); in 1990, it was $69.96, or $839.52 per year.[13]

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[12] U.S. Congress. House Select Committee on Aging. Subcommittee on Health and Long-Term Care. *Changes in the Costs of Medigap Insurance: A Fifty State Survey.* Committee Print, 101st Congress, 1st Session. Washington, D.C.: November 2, 1989. p. 1-5.

The Blue Cross and Blue Shield Association estimated the 1990 premium increases for medigap policies offered by Blue Cross/Blue Shield. The median nongroup annual premium was $576 in 1989; the median increase for 1990 prior to the repeal of MCCA was projected to be 9 percent, or $52. The median 1990 rate increase after the repeal of MCCA was projected to be an additional 29 percent, or $167. Together, the median increase for 1990 would total $219, or 38 percent, with an annual premium of $795.

Few surveys have examined medigap policy benefits. In its June 1989 issue, *Consumer Reports* magazine rated 28 medicap policies, ranging in price from $500 to $1,300 per year.[14] All of the policies reviewed by *Consumer Reports* covered the inpatient deductible; about 60 percent covered the cost of SNF care after Medicare's 150 days of coverage, less than 50 percent covered the $75 Part B deductible, and half included an outpatient prescription drug benefit.

Although Section 1882 of the Social Security Act was enacted in response to abusive sales practices in medigap policies sold to the elderly, some violations persist. Testimony by consumer groups and others before the House Committee on Energy and Commerce in April 1989 and before the Senate Finance Committee in June 1989 and February 1990 cited a variety of abusive sales practices, including: Selling policies which duplicate coverage that the customer already has; generating lists of names to sell to insurance agents through ads offering information about Medicare; and "twisting" which occurs when the customer is encouraged to switch or twist old policies for new ones because of higher commissions on new policies.

NAIC and others believe many of these problems can be addressed through consumer education, increased penalties for selling duplicative coverage, and greater restrictions on celebrity advertising. The Senate Aging Committee will hold hearings in 1990 to determine the best way to address these problems.

2. Issues and Legislative Actions

(A) CATASTROPHIC HEALTH CARE LEGISLATION

The 100th Congress was dedicated to the development of a catastrophic health care law. The MCCA was passed by the Congress and heralded as the most significant expansion of Medicare since its inception. Amid a groundswell of public outcry against this new law, and in particular, its financing, the first session of the 101st Congress quickly became dedicated to determining if it could be possible to restructure rather than repeal it. Just over 1 year after the legislation was passed, however, the Congress, concluded that the legislation could not be saved in any form and repealed MCCA.

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[13] U.S. GAO. *Medigap Insurance: Expected 1990 Premiums After Repeal of the Medicare Catastrophic Coverage Act.* Testimony of Janet Shikles before the U.S. Senate Special Committee on Aging. Harrisburg, PA, January 8, 1990. p. 5–6.

[14] "Beyond Medicare." *Consumer Reports*, June 1989, p. 375-391.

(1) Defining Catastrophic Illness

Prior to addressing the shortcomings of public and private health insurance protection against the costs associated with a catastrophic illness, a definition of the term had to be developed. While most agreed that a catastrophic illness could be defined as a major—usually unexpected—financially unmanageable illness, there were varying opinions on what amount of health care expenditure qualifies as a true catastrophic expense. In response, many rather arbitrarily chose a specific figure, for example $2,000, to define a catastrophic health care expenditure. Other health policy analysts advocated the use of a certain percentage of total annual income, for example 10 percent, to obtain a more accurate picture of the number of people who experience catastrophic health care expenses.

Because the percentage approach takes into account the financial means of the ill person, few disputed its superiority. Such an approach helped illustrate that a $2,000 health care bill for someone making $12,000 a year represents a catastrophic expense, while the same bill for someone earning $100,000 a year may not. At the same time, however, few questioned the practical administrative and political difficulties of being able to use the percentage method to set qualifications for a major expansion of the Medicare Program. Therefore, while Members of Congress and the administration used every measuring method available to guide them in constructing the catastrophic health legislation, they chose to rely upon a minimum base health care expense figure to set eligibility provisions.

(2) Shortcomings of Current Medicare Coverage

In recent years, the fact that there are major gaps in catastrophic health care insurance for millions of Americans of all ages has not been questioned significantly. Even with Medicare, the elderly remain susceptible to catastrophic health care costs. Using varying thresholds and percentages of income figures, DHHS estimated that as many as 2.1 million elderly (8.1 percent) experienced catastrophic health care expenses in 1987.[15]

Although Medicare provided excellent hospital benefits, coverage for long-term hospital stays (more than 60 days) was limited and left elderly patients vulnerable to catastrophic out-of-pocket expenses. In 1988, after day 60 in a hospital, the Medicare beneficiary was liable for a $135 daily copayment. After day 90, the same beneficiary has to pay $270 a day. At these rates, such expenses quickly can become "catastrophic."

Other non-Medicare-covered expenses that either can be or contribute to becoming catastrophic costs are the expenses associated with long-term nursing home care, outpatient prescription drugs, and physician charges above the Medicare assigned rate. In addition, expenses incurred from optical, dental, and hearing services and products continue to represent a significant out-of-pocket cost burden that are not covered by Medicare.

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[15] U.S. Library of Congress, CRS. Catastrophic Health Insurance: Medicare. Issue Brief NO. IB 87106, by Jennifier O'Sullivan, Oct. 30, 1987 (continually updated). Washington, 1987, p. 2 and DHHS, Catastrophic Illness Expenses. Report to the President, Nov. 1986.

Without question, the greatest catastrophic health care expense is that associated with the provision of long-term nursing home care. At an average annual cost of $22,000 a year, nursing home expenses dwarf all other non-Medicare-covered services. It has been estimated that one-third of elderly households would be financially ruined if one family member were to spend 13 weeks in a nursing home. The beneficiary will qualify for Medicaid assistance only after becoming, for all practical purposes, destitute. (Further discussion of this problem can be found in chapter 8.)

Although long-term nursing home care is extremely expensive, and despite the fact that one in four elderly can be expected to require nursing home care at some point in their lives, the likelihood of needing such care pales in comparison to the likelihood of requiring prescription drugs. Every year, 75 percent of all older Americans consume prescription drugs. For many elderly, the cost of these non-Medicare-covered outpatient prescription drugs can run into the hundreds, and even thousands, of dollars per year. An AARP survey found that, of those elderly who regularly take prescription drugs and do not have private supplemental health insurance which covers these costs, 40 percent spent more than $360 on prescribed drugs in 1986. For low-income elderly on fixed incomes, these high costs can and do represent catastrophic expenses.

Further, because prescription drug prices have increased at a rate two and a half times faster than the rise in consumer prices from 1980 through 1986, many insurers have dropped coverage of prescription drug costs from their medigap policies. Most, if not all of those policies that continue to offer the benefit have significantly increased their premiums, making it extremely difficult for many elderly to afford the coverage.

Right behind prescription drug expenses, non-Medicare-covered physician charges represent the next highest out-of-pocket liability. Although Medicare reimburses 80 percent of what the program considers a reasonable charge, physicians who do not accept assignment can and do charge more than the program-determined reasonable charge. As a result, Medicare beneficiaries not only are liable for the remaining 20 percent of the charge Medicare deems reasonable, but also are liable for any amount over and above the Medicare assigned rate. From 1980 to 1986, beneficiary liability for noncovered physicians costs increased by almost 100 percent, from $1.45 billion to $2.8 billion.[16]

Private insurers offering supplemental insurance (medigap) coverage to the elderly have been hesitant to offer policies that do more than build upon what Medicare covers. Consequently, many elderly have found it particularly difficult and/or unaffordable to find policies that cover long-term nursing home and home health care, prescription drugs, and physician costs that are more than the Medicare approved rate. It appears, therefore, that until a significant private and/or public insurance initiative is developed to address these and other shortcomings, the elderly—particularly the low- to middle-income elderly—will continue to live in fear of incurring catastrophic health care costs.

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[16] Varner, Theresa. Catastrophic Health Care Costs for Older Americans: The Issue and Its Implications for Policy Development. AARP Public Policy Institute, June 1987, p. 16.

Millions of nonelderly Americans are at least as vulnerable to catastrophic health care costs. There are 37 million persons under 65 who have no health insurance and are completely vulnerable to being financially devastated by a catastrophic health incident. Moreover, millions more have indequate protection against catastrophic health care costs. Using varying thresholds and percentages of income figures, DHHS estimated that as many as 6.2 million (3.2 percent) of the under-65 population were victimized by catastrophic health care expenses in 1987.[17] And finally, as pointed out by a Senate Aging Committee sponsored report series by the Congressional Research Service, the percentage of the under-65 population who is uninsured increased from 14.6 percent in 1979 to 17.5 percent in 1986. Despite receiving a great deal of attention of the 1986 DHHS catastrophic health care report and in a number of congressional hearings in 1987 and 1988, the lack of health insurance protection of the under-65 population was not addressed in the MCCA.

(3) *Administration's Actions to Address Shortcomings*

When President Reagan initially mentioned his desire to find ways to better protect Americans against catastrophic health care costs in his 1986 State of the Union Address, he started the ball rolling toward the almost inevitable passage of legislation which begins to accomplish this goal. Although it was not a new issue (many Members of Congress had introduced legislation in previous sessions), the administration's willingness to move forward on the catastrophic health care front breathed new life into the issue.

(a) *Bowen report on catastrophic health care*

In the 1986 State of the Union Address, the President announced that he had directed the Secretary of DHHS to study the catastrophic health care issue and develop recommendations to address health insurance shortcomings. Although an encouraging development, many critics were skeptical of what, if anything, would come of this report. However, when the report was released in 1986, most of the critics were pleasantly surprised and praised Secretary Otis Bowen for the scope of the study and the thoughtfulness of the report's recommendations.

The report provided a comprehensive analysis of the shortcomings of current public and private insurance coverage of catastrophic health care legislation. It focused on three vulnerable groups: The elderly who face large out-of-pocket costs associated with lengthy, non-Medicare covered hospital stays for acute illnesses, older Americans who require long-term care, and the vulnerable uninsured and underinsured under-65 population.

To meet health policy analysts, the report's recommendations for addressing the lack of catastrophic protection for the under-65 population and for those elderly needing long-term care were not unexpected. These recommendations placed heavy emphasis on encouraging (through tax incentives) the development of private sector, State, and local initiatives.

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[17] U.S. Library of Congress. CRS. Catastrophic Health Insurance: Medicare. Issue Brief 87106, p. 2.

Specifically, Secretary Bowen's long-term care proposal consisted of recommendations to: (1) Provide tax incentives and other inducements for the private sector to develop and market long-term care insurance more actively, (2) encourage the use of individual medical accounts (IMA's) in a way that individual retirement accounts (IRA's) had been used prior to the Tax Reform Act of 1986, and (3) provide much-needed information to the public about the costs, potential for requiring, and the limitations of Medicare coverage of long-term care.

The administration made similar recommendations with regard to catastrophic protection for the under-65 population. To encourage employers to provide catastrophic protection for their employees, the Secretary recommended comprehensive tax deductions to those who provided such coverage to their employees. With regard to State involvement, the proposal which received the most attention was a recommendation to encourage States to develop, with guidance from the Federal Government, insurance risk pools for medically uninsurable citizens (those who cannot obtain insurance due to previous major medical conditions and/or lack of income). Risk pools would require that all health insurers in the State contribute to developing and offering a feasible health insurance option for these high-risk populations.

Although the analysis of the numerous problems surrounding the lack of long-term care insurance for older Americans and catastrophic health care protection for the under-65 population was comprehensive, the proposed recommendations to deal with these problems were viewed by many health policy analysts to be inadequate and/or politically unrealistic. The long-term care proposals were criticized on the grounds that their tax incentives might well benefit the relatively wealthy, but would leave large gaps in protection for middle to lower income brackets. In particular, critics argued that IMA's, like IRA's, would be taken advantage of primarily by upper middle to upper income groups. Further, bipartisan criticism pointed to the fact that the IMA recommendation was inconsistent with a provision of the 1986 Tax Reform Act which significantly limited the use of IRA's. The proposals to deal with the underinsured and uninsured under-65 population were given similarly negative reviews, and—like the long-term care proposals—were not incorporated into any catastrophic legislation.

Far and away the most widely heralded—and surprising—recommendation was the Secretary's proposals to restructure the Medicare Program to include a beneficiary-financed, actuarially sound, acute care catastrophic benefit. This was an unusual departure for an administration official because it represented one of the first Reagan Administration health proposals to depart from its customary reliance on the private sector and/or the States to address a critical need.

While Secretary Bowen's acute catastrophic care recommendation received praise from many in the Congress, it also was the recipient of much criticism from conservatives in and outside of the White House. In a New York Times article, Peter J. Ferrara, a former Reagan domestic policy adviser, called the proposal "reverse privatization, blatantly and directly contrary to the President's policies." Despite the criticism and after much debate within the White House, Secretary Bowen's acute care catastrophic proposal eventually was endorsed by the President and served as the basis not only for the legislation the administration submitted to the Congress, but also for all other catastrophic bills as well.

(4) Congressional Response

The Congress, weary and frustrated of its role of spending the majority of its time trying to control health care costs rather than address health care needs, heartily welcomed Secretary Bowen's report. After a long respite, the administration finally had opened its doors to the possibility of a major health initiative. Members quickly recognized that, regardless of whether the President followed the report with an endorsement for legislation, they could use the report and its recommendations as a vehicle for legislative action. Even prior to the introduction of the administration's bill, Members of Congress quickly scheduled hearings on the catastrophic health care issue and introduced various versions of the legislation.

The House of Representatives moved more rapidly than the Senate in developing, introducing, marking up, and passing the catastrophic legislation. However, the primary debate in both Houses of Congress consistently centered around how the benefit would be financed and whether it would cover prescription drugs.

Despite great initial momentum to sign catastrophic health care protection legislation and despite the fact that separate catastrophic health bills were passed in both Chambers of the Congress in 1987, a compromise between the two bills was not achieved until June 1988. The delay was the result of many factors, including concerns about the prescription drug benefit's costs, the fact that many of the catastrophic health care bill's conferees were participating in the budget summit following the October 1987 stock market crash, and the fact that early delays in the process made it clear that there would not be sufficient time to implement the legislation before 1989. Finally, after 18 months of reports, hearings, legislative proposals, and compromising, the Congress passed and the President signed the MCCA into Public Law 100-360 on July 1, 1988.

(5) Repeal of MCCA

A large outcry from older Americans followed the passage of MCCA. Seniors raised a variety of issues, but particularly focused on the financing of the new law and the benefits it covered. Some beneficiaries liable for the supplemental premium (also known as the surtax) objected to the amount they would be required to pay for the new benefits and coverage. Some beneficiaries also objected to the mandatory nature of the program. Noting that MCCA represented the most significant expansion in benefits since the enactment of Medicare, proponents cited the fact that the law filled some very significant program gaps.

Opponents were most vocal in their opposition to the surtax, however other objections fueled their movement for repeal of the law. Suggesting that individuals did not need or desire expanded Medicare coverage, critics noted that over three-fourths of Medicare beneficiaries had some health coverage in addition to Medicare. Others said that the major gap in Medicare—long-term care services—remained. Some opponents suggested that they would be paying for benefits they would never use.

Early into 1989, Senator Bentsen, Chairman of the Senate Finance Committee, announced that more surtax was being collected than would be necessary to pay for the benefits. He concluded that a reduction in the premium would be appropriate. This proposal received a great deal of media attention and there was some hope that such a move would reduce the pressure to repeal the new law. However, far from reducing complaints against the surtax, this announcement actually fueled the fire because it focused more attention on a bitterly hated surtax.

Soon after this announcement, CBO provided new estimates that projected much higher costs for the program than was originally anticipated. The root causes of the projected increases were the new drug and expanded nursing home benefits.

Members of the committees of jurisdiction (the Senate Finance Committee, the House Ways and Means Committee, and the House Energy and Commerce Committee) reacted with anger and frustration. However, even as calls for its repeal were growing louder, Members' refused to give up on their desire to save all or most of the new benefits.

Various alternative approaches to modifying MCCA were considered. Members worked for months to try to develop a way to avoid total repeal of the law. Because many of the benefits were thought to be quite important, Members were reluctant to totally eliminate the surtax that would be needed to fund these benefits. As a result, attempts were made to make significant cuts in the surtax while leaving sufficient revenue to pay for one of the three primary benefits: the Part B expansion, the expanded SNF benefit, or the new outpatient prescription drug benefit. Members who developed alternative packages included Senators Pryor, Heinz, Chafee, and Durenberger.

Complicating these attempts to save the benefits was the fact that the excess revenues coming from the surtax were being counted as revenue against the Federal budget deficit. As a result, Members found it extremely difficult to formulate approaches to reduce the surtax while retaining budget neutrality. It was therefore not surprising that repeated attempts at compromise failed to achieve any consensus.

Accepting the fact that the surtax would have to be eliminated to have any chance of saving any benefits, Members (most notably, Congressmen Stark and Gradison, and Senator McCain) developed new alternatives that reduced benefits further, eliminated the surtax and, to a large extent, ignored the desirability of budget neutrality. Therefore, the only financing mechanism remaining was the new $4 catastrophic health care premium.

Encouraged by an announcement from the administration that additional and previously unacknowledged revenue was available to address the budget neutrality issue, some in Congress felt that a compromise was in their grasp. The House reviewed the Stark/Gradison proposal (which eliminated the surtax while retaining the mammography, respite care, home health care, hospice and modified prescription drug benefit), and praised it for its attempt to save some benefits. However, it soon became clear that most House Members, extremely weary of hearing constituent complaints, had concluded the die was cast and the only solution was outright repeal. On October 4th, the House voted 360 to 66 to support an amendment offered by Congressmen Donnelly and Archer to repeal all benefits with the exception of the few Medicaid benefits.

The Senate was not yet as willing to give up. On October 6th, they overwhelmingly passed the McCain Amendment (which retained the Part A hospital benefit, the immunosuppressive and home IV drug benefit, the mammography services, and the respite care benefit), and sent what they felt was the best remaining approach back to the House. Surprising some, the House refused to bend toward the Senate. Even some of MCCA's earliest and strongest supporters sensed it was too late to save anything. On November 6th, they voted again to repeal. The Senate however, refused to alter its position and, on the same day, continued to support and passed a modified McCain proposal.

A joint Senate/House conference was formed to work out a compromise between the two provisions. After meeting several times, it became clear that neither side was willing to significantly modify its position. On November 19th, the conferees reported the House repeal measure with a few modifications. Not surprisingly, the Senate rejected this measure. In fact, the Senate rejected this approach on two separate occasions. However, the House insisted on the conference agreement and its repeal provisions and voted overwhelmingly to repeal the entire program. Finally, on November 22, 1989, the Senate deferred to the House position and voted for the repeal of the 16-month-old MCCA law.

Most provisions, including the new Medicare benefits and the financing provisions, were repealed by H.R. 3607. A few provisions were maintained. H.R. 3607 amended the original MCCA procedures for Federal certification of Medigap policies to reflect repeal of catastrophic coverage. Some important Medicaid provisions were retained. The provisions retained included: (1) Requiring Medicaid to pay Medicare premiums and cost-sharing charges for Medicare beneficiaries below poverty; (2) spousal impoverishment provision which, in the the case of the institutionalization of one member of a couple, provides protection for a portion of the couple's income and resources for the maintenance needs of the community spouse; and (3) requiring Medicaid coverage of pregnant women and infants below poverty. H.R. 3607 also retained the modified calculation of the blood deductible and the provision which established the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission).

(B) MEDICARE SOLVENCY AND COST CONTAINMENT

Controlling health expenditures within the Medicare Program and looking for ways to assure the program's solvency well into the next century continue to be among the highest priority issues for both the Congress and the administration. Total costs for Medicare have steadily increased from $4.6 billion in 1967 (the first full year of the program) to an estimated $86.9 billion in 1989.[18] By 1990 Medicare outlays are expected to reach more than $100.75 billion.[19]

The rise in Medicare costs has been a concern on two levels. First, Medicare has been consuming an increasing share of the Federal spending. In 1988, outlays for Medicare represented 7.4 percent of the total Federal budget.[20] This compares with a little more than 4 percent in 1976. With Federal deficits expected to remain close to $152 billion in fiscal year 1989, there are continuing pressures to curb the growth in Medicare outlays. As the second most expensive domestic program, it provides a major target for deficit reduction efforts. While Part A is funded out of the trust fund, Part B is largely funded out of general revenues making it a prime target for annual spending cuts. Under current law, 25 percent of the Part B program is financed by premiums paid by beneficiaries. The bulk of Part B expenditures goes to pay for physician services. Thus, as physician payments increase, so too will pressures on the General Treasury to finance Part B—a fact that has underscored the need to bring effective cost containment to physician services and other Part B expenditures.

A second driving force for Medicare cost containment is the need to assure solvency of the trust fund. The introduction of the Prospective Payment System, along with other factors slowing inflation in the medical marketplace, has given new life to the trust fund. In 1984, the Medicare trustees were estimating that the HI trust fund would go bankrupt by 1989 under pessimistic economic assumptions and by 1992 under intermediate economic assumptions. In the 1985 report, the trustees revised their projections, estimating that the HI trust fund would remain solvent until 1998 under intermediate economic assumptions, and until 1992 under pessimistic ones. In the 1988 HI trustees report, the trustees again revised their projections, moving forward the date of insolvency under intermediate assumptions to 2005-2008, and 1999 under pessimistic assumptions.[21] The trustees did not issue a report in 1989.

Despite the 1988 projections, there remains a legitimate concern that the present financing schedule for the HI trust fund is inadequate to ensure its long-term health. According to the trustees, "in order to bring the hospital insurance program into actuarial balance even for the first 25-year projection period under alternative II-B assumptions (intermediate economic assumptions), either outlays will have to be reduced by 14 percent or income increased by 16 percent (or some combination of these."[22] Moreover, because of changing demographics, increasingly fewer workers will be available to support each Medicare beneficiary as we move into the next century. Today, four covered workers support each Medicare enrollee. By the middle of the next century, there will be only slightly more than two covered workers supporting each enrollee. According to the trustees, however, all but the most optimistic assumptions indicate that there will be insufficient reserves in the HI program even before this major demographic change begins to occur. Therefore, there is a growing need to find ways to ensure the same level of benefits to future generations of the elderly.

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[18] Table 6, 1987 SMI Trustees' Report, Hospital Insurance Trust Fund Report.

[19] Congressional Research Service Issue Brief IB89029, Medicare fiscal year 1990 Budget, by Kathleen M. King and Mark Merlis, December 1989.

[20] Ibid.

[21] 1988 HI trustees report, p. 55.

[22] DHHS, HCFA Financing Administration, 1988 Annual Report to the Trustees of the Federal Hospital Insurance Trust Fund. Washington, May 5, 1988, p. 51.

While there is evidence that indicates that the implementation of the prospective payment system has made a contribution to slowing the increases in Medicare inpatient hospital expenditures, the jury is still out on the degree of its success. At a time when health care inflation is still consistently double the general inflation rate, there is little debate that much more needs to be done to prevent the future insolvency of the trust fund. In response, Congress may well have to make further systemwide changes to the Medicare Program.

In 1987, the Senate Finance Committee attempted to address the Medicare insolvency issue by recommending in the reconciliation legislation initially reported out of committee a provision to repeal the Medicare payroll tax exemption for earnings in excess of the statutory wage base. Under current law, the Medicare payroll tax is 1.45 percent for both the employee and the employer up to a maximum level of $45,000 in 1988 and $48,000 in 1989. The Finance Committee proposal would have removed the $45,000 cap and required the 1.45 percent Medicare payroll tax be paid on all earnings. It was estimated that this proposal would raise $2.2 billion in fiscal year 1988 and $15.4 billion over 3 years. The Finance Committee argued in favor of this proposal for several reasons, including:

(1) It would begin to address the long-term solvency needs of the Medicare trust fund.

(2) It would eliminate the regressivity of the Medicare payroll tax by making the 1.45 percent rate uniform for all workers. Currently the more a person earns in excess of the wage base, the lower his or her effective rate is.

(3) It would apply to only the most highly paid workers—those earning in excess of $45,000 in 1988. There would be no effect on the 92 percent of workers who earn less than that and a two-earner family could earn up to $90,000 without being affected.

(4) It would not repeal the wage base cap on the Social Security payroll tax. Under Medicare, all eligible beneficiaries receive the same coverage, regardless of the amount of the worker's contribution. Unlike Medicare, Social Security benefits are based on the amount of contribution. A dollar cap on the taxable wage base is more appropriate for the Social Security tax because it prevents the benefit formula from generating unduly large benefits.

Despite serious consideration, the proposal to remove the Medicare payroll tax cap was not included in the final reconciliation legislation. During the budget summit following the October stockmarket crash, the administration indicated that it would not support this tax increase. Further, many Members of Congress had been looking at this source of funding for, among other items, an expansion of the Medicare long-term care benefit. In light of the opposition to this proposal from both sides of the political fence, it was not surprising that the proposal did not reach the President's desk when he signed the Omnibus Budget Reconciliation Act (OBRA) of 1987 into law.

Although not significantly addressed in 1987 or 1988, the need for comprehensive Medicare reform will not disappear. There continues to be no consensus about how reform is to be achieved. However, beyond the 1987 Senate Finance Committee approach, options include tapping new sources of revenue for the trust fund such as additional premiums, dedicated additional excise taxes on tobacco and alcohol, and funds from general tax revenues. Other options propose to transform the basic mode of health care delivery to a delivery system dominated by organizations that manage the provision of health care, such as health maintenance organizations and competitive medical plans. Still others suggest that Medicare costs can be contained by cutting back coverage, by requiring a means test for eligibility, or by altering payment incentives to make providers more efficient.

Whether these or other courses of action are selected as the options in the future, it appears clear that Congress and the administration cannot wait too much longer before taking steps toward comprehensive reform of the Medicare Program.

(C) COST OF PRESCRIPTION DRUGS

Prior to even assuming the chairmanship of the Senate Special Committee on Aging, Senator Pryor announced his number one priority would be to find a way to reduce or control rapidly rising prescription drug prices. Consistent with this desire, he directed the Committee to immediately begin an investigation into this issue.

Following a multimonth investigation, Chairman Pryor convened two hearings on the high cost of prescription drugs, in July and November 1989. These hearings addressed reasons for the rising cost of prescription drugs, as well as possible solutions that may be applicable to State Medicaid programs.

During these hearings, the Committee documented that prices for prescription drugs had increased by 88 percent from 1981 to 1988, a period during which the Consumer Price Index increased only 28 percent. In addition, it was found that the great majority of new drugs injected into the U.S. market are therapeutically equivalent or "me-too" medications that offer little or no potential for therapeutic gain. Despite this fact, these drugs were found to be actually much more expensive and serve to drive up drug costs in public and private insurance programs.

Findings from the investigation included:

—Since 1984, Medicaid prescription drug expenditures have risen more rapidly than Medicaid expenditures for all but home health care and facilities for the mentally retarded.

—State Medicaid prescription drug programs have had little to no success in negotiating directly with drug manufacturers for better prices and, as a result, have found the only way to control costs is to reduce coverage, increase copayments, or cut back on reimbursement to pharmacists.

—Based on the knowledge that many different drug products are often used to treat the same medical condition, hundreds of hospitals and HMOs have forced drug manufacturers to compete and offer reduced prices.

—Prescription drug manufacturers have waged an all-out campaign to undermine and frustrate State efforts to negotiate lower prices for drugs. Opposition from drug manufacturers has succeeded in blocking 13 out of 15 States' previous attempts to negotiate lower drug prices for their financially strapped Medicaid programs. The States currently negotiating with manufacturers have been successful only on a limited basis.

—Medicaid programs pay much higher prices than hospitals and HMOs for the same drug products because they have been unable, or have been unsuccessful in attempting, to use their formulary process to negotiate reasonable drug prices with drug manufacturers.

—The most successful formularies: (1) are founded on sound clinical judgment of physicians and pharmacists regarding the therapeutic interchangeability of drugs; (2) ensure the availability of at least one (and sometimes several) high quality prescription drugs in each therapeutic group of drugs; (3) enable physicians to readily obtain an off-formulary drug when necessary; and (4) are not finalized until manufacturers of interchangeable drugs have been offered the opportunity to bid lower prices and thereby earn a listing on the formulary.

Using these findings as a springboard, Chairman Pryor announced his intention to introduce a bill in the second session to assist States control their Medicaid prescription drug program costs. This bill would take advantage of sound business principles, currently operating in the private sector, to secure reasonable drug prices by developing an approach that brings drug manufacturers to the bargaining table.

Specifically, the Chairman's proposal would direct the DHHS Secretary to establish a medical and scientific panel that would review prescription drugs, with the aim of determining which products are equally safe and effective therapeutic alternatives. This panel, which would be much like similar panels in hospitals and HMO's, would produce a list of therapeutically equivalent products that would then be used by States to negotiate drug prices with manufacturers.

Under this proposal, manufacturers of therapeutically equivalent drugs would have to negotiate with the States to place their product on the "preferred drug list;" however, any drug would still be covered if the patient's physician handwrites on the prescription "(drug name) medically necessary." Chairman Pryor advocated this approach because he felt the physician "override" feature would assure that any preferred drug list did not restrict medications that doctors felt were necessary.

Preliminary estimates projected that a proposal such as Senator Pryor's could save between $100 million and $250 million a year in Medicaid prescription drug program expenditures. Already by the end of 1989, a number of States, severely strapped by out-of-control Medicaid expenditures, had indicated significant interest in the Chairman's concept.

Although the proposal received a great deal of preliminary interest and support, there was at least one extremely organized and well-financed opponent to it. By the end of the year, drug manufacturers publically stated that the defeat of any such proposal would be their number one priority in 1990. There is little question that there will be quite a debate around this issue in the upcoming months of the second session of the 101st Congress.

(D) ADMINISTRATION'S FISCAL YEAR 1990 BUDGET PROPOSAL

The President submitted a budget that was viewed to disproportionately and unfairly cut the Medicare Program. However, the cuts were not as hard on beneficiaries as they had been during the Reagan years. The President's fiscal year 1990 proposed budget provided $95 billion in outlays for the Medicare Program, approximately $3.5 billion below the amount needed to maintain the fiscal year 1989 level of services. Over a 5-year period, these proposed cuts totaled an estimated $14.6 billion. The administration's proposed cuts included additional reductions of $2.4 billion in Part A and about $1.1 billion in Part B, a total of $3.5 billion.

(1) Beneficiary Impact

The administration's fiscal year 1990 budget proposed to extend the 25-percent rule, which requires Medicare Part B premiums to cover 25 percent of the program's costs. From 1984 through 1989, the Part B premium was set at 25 percent of program costs for the elderly. This was estimated to provide a $617 million offset to outlays. The administration considers the 25 percent share to be a reasonable split of the burden of program costs between the Government and beneficiaries. However, out-of-pocket medical costs are consuming a growing portion of the elderly's income.

(2) Provider Impact

A number of proposals to reduce reimbursements to providers by $1.1 billion in fiscal year 1990 were included in the administration's budget. Over a 5-year period, these proposals would amount to $16.8 billion in cuts. Key provisions include:

Physician services.—The administration proposed to cut payments for overpriced procedures by amounts up to an additional 12 percent. Five-year savings were estimated at $505 million. In addition, payments to cover radiology, anesthesiology, and surgery services were proposed to be reduced by 8 percent in fiscal year 1990, resulting in 1-year savings of $250 million and 5-year savings of $1.5 billion. For nonprimary care services, the administration proposed no increase in prevailing charges for 1990, and a 1-percent increase in 1991 and 1992. For primary care services, the administration proposed to increase the prevailing charges by the full Medicare Economic Index each year.

Durable medical equipment.—Proposed to reduce payments for durable medical equipment (i.e., wheelchairs, hospital beds, etc.), oxygen supplies, and renal dialysis services by $160 million in fiscal year 1990. The administration's proposal included provisions to: Modify the fee schedule for DME rentals; reduce oxygen payments by 5 percent; and set fee schedules for enteral products and supplies (i.e., nutritional products and medical equipment designed for those who are unable to ingest food).

Medical education.—Proposed to reduce payments to hospitals for the direct costs of medical education (namely, residents and teachers salaries and classroom expenses) by $150 million in fiscal year 1990. Proposed cuts amounting to $1,020 million in fiscal year 1990 for payments for the indirect costs of medical education (the costs of additional tests and procedures prescribed for purposes of learning).

(3) Coverage of State and Local Employees

As a revenue raising measure, the President's budget proposed mandating Medicare coverage of all State and local employees. Under current law, Medicare coverage and hospital insurance taxes are mandatory for new State and local government employees hired on or after April 1, 1986. States have the option to extend Medicare coverage to State and local government employees hired before April 1, 1986. This proposal would have yielded almost $2.3 billion in fiscal year 1990 and $10.3 billion over the next 5 years in revenues, which would flow to the Medicare trust funds.

(4) Fiscal Intermediaries

The President proposed to increase the amount paid to Medicare's contractors, primarily Part A intermediaries and Part B carriers who review and process claims. The President's fiscal year 1990 budget requested $1.5 billion, $79 million above fiscal year 1989.

(E) CONGRESSIONAL RESPONSE

The administration's proposed budget cuts were felt to be overly harsh and the Congress worked hard to modify them. Congress again concluded that Medicare cuts could not be achieved by placing additional out-of-pocket burdens on the elderly. As a result, the budget reductions that survived the congressional obstacle course were targeted at providers and not beneficiaries. The fiscal year 1990 Medicare cuts to providers amounted to $3 billion. The major health policy issues, which were raised and/or addressed both in and outside of the budget process, are outlined in the following sections.

(1) Issues Affecting Medicare Beneficiaries Out-of-Pocket Costs

When Medicare was established in 1965, the Part B premium was set at an amount that would cover 50 percent of program costs. The Social Security amendments of 1972 modified this requirement to limit increases in premium amounts to the percentage increase that Social Security beneficiaries received in their COLA. Because program costs increased well beyond the inflation rate on which COLA's are based, the portion of program costs covered by the premium declined to less than 25 percent by 1982. The Tax Equity and

Fiscal Responsibility Act of 1982 set the premium at the level necessary to cover 25 percent of program costs through 1986. This provision subsequently was extended through 1988 by the Deficit Reduction Act of 1984, through 1989 through OBRA 1987, and extended again until the end of 1990 by OBRA 1989.

In September 1987, HCFA announced that the Part B monthly premium would be increased an unprecedented 38.5 percent in 1988 from $17.90 to $24.80 to meet the 25 percent of program costs requirement. HCFA explained that the three factors influencing the increase were: (1) Earlier projections for 1987 expenditures and utilization (primarily related to costs associated with physician services) under Part B were too low; (2) the Part B program is projected to continue its current rate of growth; and (3) due to a surplus in the Part B trust fund, the 1986 and 1987 monthly premiums were, in effect, discounted as a result of the contingency reserve fund being drawn down.

Congressional hearings to examine the issue found that while the increase was justified and somewhat expected, it was nonetheless overly burdensome to many Medicare beneficiaries, particularly those with low incomes. Although the 1989 premium increased only 12.5 percent (to $27.90, not including the $4 monthly catastrophic premium), no changes were made to ensure that the premium will not increase by a large amount again. Medicare beneficiaries were paying 963 percent more in Part B premiums in 1989 ($27.90 + $4 = $31.90/month × 12 months = $328.80) than they were in 1966, when the premium was $36 per year. The 1990 premium increased 4 percent, to $29. Beneficiaries will no longer have to pay the flat $4 premium for the MCCA.

(2) Issues Affecting Home Health Care

In 1983, Medicare changed the method for paying hospitals from a pay-as-you-go system to a prospective payment system based on predetermined rates for specific diagnosis-related groups. Since then, Medicare patients have been sent home from the hospital after shorter stays and in greater need of follow-up health care. At the same time, HCFA has targeted the home health benefit for continual cutbacks, lower payment levels, and narrower interpretation of the scope of the benefit. As a result, more Medicare beneficiaries need home health care at a time when less care is available.

Large numbers of Medicare patients who are discharged "quicker and sicker" often find post-hospital care unavailable or substandard. The stress on post-hospital services is increasing substantially. In addition, existing hospital discharge planning programs—important mechanisms for assuring that patients are placed in appropriate community settings—are seriously overtaxed under PPS with the result that Medicare patients often receive inadequate post-hospital care.

Adding to the problem is the fact that HCFA has sought to reduce nursing home and home health care utilization through administrative denials of reimbursement. While increasing numbers of seriously ill Medicare patients are in need of home health care, home health care denials have nearly tripled since the first quarter of 1983 when PPS was initiated. During this period, the rate of growth in home health services slowed. Medicare-covered visits rose an average of 18 percent from 1980 to 1983, compared to a rise of only 1.3 percent during the period 1983 to 1986. In addition, the number of persons served using home health benefits rose by an average annual rate of growth of 12.2 percent during 1980 to 1983, compared to 5.8 percent for the period 1983 to 1986. Federal policies to restrain beneficiary protections, combined with vague and confusing guidelines for providers, have resulted in reduced access to home health care for older Americans.

Further, HCFA's use of unwritten and unpublished guidelines further limit the Medicare home health benefit. HCFA has repeatedly attempted to eliminate the "waiver of liability" which gives home health agencies critical flexibility in interpreting Medicare rules and regulations so they are not forced to deny access in cases where eligibility is in question. In addition, HCFA has placed limits on home health providers' abilities to appeal decisions denying Medicare beneficiaries home health care and has made it very difficult for Medicare beneficiaries to appeal decisions themselves.

Finally, little attention from the Federal level has focused on the quality of care that home care agencies provide. The evaluation of quality of care by HCFA has focused on the home care agency's organizatonal form, the facilities and equipment, its staff's credentials, and its fiscal management. These standards tend to measure an agency's capacity to deliver services rather than the quality of the services actually provided.

OBRA 1987 included many provisions aimed at improving the Medicare home care benefit. The key provisions affecting home care included in OBRA 1987 are:

> *Publication of policies.*—HCFA must promulgate regulations on any new policies that change the legal standard governing benefits and eligibility for Medicare coverage. HCFA must ensure that the practices of fiscal intermediaries and carriers are consistent and clearly understood by service providers as well as beneficiaries. Also, the fiscal intermediaries must have mechanisms for consultation with representatives of health and skilled nursing home providers and consumers in their region regarding problems of claim review and coverage guidelines.
>
> *Denials.*—HCFA's fiscal intermediaries must give to the home care provider and beneficiary a written explanation of any denial of a claim for home health or SNF services, including the statutory and regulatory basis for the denial.
>
> *Homebound definition.*—OBRA 1987 clarifies the homebound definition so that even if a person is able to leave his or her home for short periods of time, he or she is still considered homebound.
>
> *Home health prospective payment.*—HCFA must conduct a study and demonstration of alternative methods for paying home health agencies under Medicare on a prospective basis, taking into consideration the effects of these methods on access and quality of care.
>
> *Tougher survey and certification process.*—HCFA must establish a revised certification survey that focuses on the quality of patient care and the effect of that care on the patient. This

strives to ensure that the capacity to deliver care actually translates into the provision of high quality care. Rights for home care consumers are clearly delineated and quality monitoring surveys of home care agencies will be conducted annually and unannounced. The inspection process must include actual visits with and interviews of patients. Intermediate sanctions for poor quality also are establsihed, including civil fines and denial of Medicare reimbursement for future Medicare patients. Finally, employees of home care agencies, including home-health aides, would be required to meet approved training standards.

Home health hotline and investigative unit.—All State agencies that certify home health agencies for participation in Medicare must collect certain information on Medicare-certified agencies, including significant deficiences relating to patient care, corrective actions taken, and sanctions imposed. Agencies must also provide for a toll-free hotline to receive complaints and answer questions with regard to home health agencies and for a unit to investigate these complaints. The unit will have enforcement authority and access to survey reports and consumer medical records.

As the elderly population increases, so too will the need for quality home care. Because of past problems with HCFA's administration of the Medicare home care benefit, the Aging Committee will continue to monitor the performance of DHHS in this area to make certain this need is met. The April 1988 report from the Aging Committee entitled "Home Care At the Crossroads," outlined the major issues that need to be addressed to improve access to and the quality of home care services for the elderly. While many of these issues were addressed in OBRA 1987, the report details other concerns, such as the fragmentation of services, that OBRA 1987 did not address. Many older persons are receiving inadequate home care because various funding sources and differing eligibility requirements, often with restrictive interpretations, beget fragmentation of services. There also is a lack of adequate public and private funding for the kind of supportive, long-term care that many older persons need. Home Care at the Crossroads also discusses the problems concerning home care employees, who are frequently paid very low wages and are undertrained, often resulting in absenteeism and high staff turnover.

(3) Issues Affecting Hospitals

In 1989, as in previous years, Medicare hospital payments became a major target for budget cutting efforts as the Congress sought to meet the deficit reduction targets of the Gramm-Rudman-Hollings law. This fact, combined with efforts to refine the Medicare hospital PPS, created a challenging setting within which the Congress and the administration sought to resolve health policy and deficit reduction demands. Throughout the budget debate, priority was placed on consideration of hospitals which would be particularly vulnerable to further cuts, and in preserving the largest possible hospital payment update within the tight budget constraints.

(a) Quality of care issues/peer review organizations

When Congress enacted Public Law 98-21 establishing Medicare's PPS, there was a general recognition that inherent in the newly structured payment system were incentives to underserve patients and discharge patients prematurely. To ensure against these outcomes, Congress charged PRO's with monitoring quality of care as well as utilization outcomes.

The Senate Special Committee on Aging has been actively involved in investigating problems regarding the delivery of quality health care under Medicare. The committee's efforts uncovered serious deficiencies related to earlier hospital discharges, denial of access to needed services, inadequate rights of appeal, pressures on physicians to provide care at a lower level than that which would be considered sound medical practice, limited focus of PRO activities, inadequate post-hospital care, and the lack of adequate data regarding the quality of health care provided under PPS. Related committee activities uncovered serious limitations on the part of the Federal Government to protect beneficiaries from incompetent and dangerous medical practitioners.

As part of the OBRA 1986, the Congress enacted a number of quality of care reforms. Among the new reforms enacted were the written notice to patients of hospital discharge rights, an improved discharge planning process, a study of payments for administratively necessary days, allowance for provider representation of beneficiaries during certain benefit appeals, and a number of PRO improvements including the requirement that PRO's review the quality of care provided.

The Medicare and Medicaid Patient and Program Protection Act was signed into law on August 18, 1987. This law mandatorily excluded from participation in Medicare, Medicaid, Maternal and Child Health Block Grant, and the Social Services Block Grant, any medical practitioner (whether an individual or entity) convicted of a criminal offense for neglect or abuse of a patient in connection with the delivery of a health care item or service or a criminal offense relating to delivery of a service under Medicare or a State health care program. Among its other provisions, the law specifies a number of circumstances under which the Secretary of DHHS is granted the discretion to exclude providers from participation in State and Federal health care programs, makes provisions for the duration and appeal of such exclusions, allows for civil monetary and criminal penalties, and requires States to develop a system for maintaining statistics on and reporting of action taken against sanctioned providers.

During 1987, congressional interest in the PRO system and its objective of ensuring the delivery of quality health care continued. OBRA 1987 included a number of changes affecting contracting and other aspects of the PRO system. Specifically, the legislation extends initial and renewal PRO contract periods from 2 years to 3 years, and allows the Secretary of DHHS to stagger the contract renewal periods. These changes are expected to foster greater stability in PRO operations, allow for more accurate evaluation of a PRO's performance, and reduce administrative contracting costs. In addition, the new law requires that each PRO offer educational sessions several times each year to hospital staffs regarding review of the hospital's Medicare services, directs PRO's (to the extent possible) to provide initial review of psychiatric and physical rehabilitation services by a physician trained in the appropriate field, and requires PRO's to consider special problems of delivering care in remote rural areas.

Also included in the OBRA 1987 were PRO provisions which require that: (1) PRO's provide reasonable notice and opportunity for discussion of denied claims and that the provider be given 20 days (for discussion and review) before the payment denial would be effective, (2) the DHHS Secretary publish in the Federal Register (30 days before the date on which the change takes effect) any new policy or procedures that affects the performance of PRO contract obligations, (3) general criteria and standards used in evaluating PRO fulfillment of contract obligations be published in the Federal Register, and (4) the Secretary of DHHS provide documentation to each PRO on its performance in relation to other PRO's.

Several PRO provisions were considered by Congress during deliberations on the first year 1990 budget. Two major provisions passed by the Congress as part of OBRA 1989 relate to denial of payment for substandard care. The peer review community was concerned about the requirement to simultaneously notify practitioners/providers and patients of denials of payment for substandard care prior to a reconsideration opportunity for providers/practitioners. The new provision allows practitioners and providers the opportunity for reconsideration of a PRO's quality denial determination prior to patient notification. Such reconsideration would be in lieu of any subsequent reconsideration. Also included in the legislation is language specifying the content of the patient notice on quality denials, which will state: "In the judgement of the peer review organization, the medical care received was not acceptable under the Medicare program. The reasons for the denial have been discussed with your physician and hospital."

Another provision included in OBRA 1989, advanced by the American Nurses Association, requires that PRO's establish procedures for the involvement of health care practitioners who are not doctors of medicine in the review of services provided by members of their profession.

Debated but not included in the final legislation were provisions concerning pre-exclusion hearings, civil monetary penalties, and the unwillingness or lack of ability standard. In 1990, discussion and action on these issues will likely continue.

(b) Rural health care

Access to adequate, appropriate health care services in rural areas was one of the major health care issues of 1989. Rural hospitals are perceived by many health policy analysts to have a special set of problems that make them more vulnerable to experiencing significantly greater financial problems. Some of the problems may be related to cost containment and other changes that have come along with the implementation of Medicare's PPS. Other problems have arisen due to adverse economic conditions in rural areas. These problems include fewer hospital admissions, declining lengths of stay, and increasing severity of illness of the patients who are admitted to hospitals. In addition, these hospitals have fewer personnel and specialized services, lower overall occupancy rates, and serve a population more likely to be underinsured as well as older than average. As a result of these differences, many experts believe these hospitals have been more vulnerable to recent Federal health cost containment policies.

The debate among health policy experts whether steps should be taken by the Federal Government to prevent the closing of rural hospitals, especially those which are the sole providers in their area, continues as an increasing number of rural hospitals close their doors. While such hospitals may not be economically efficient, they often play a role in the community that goes beyond the provision of inpatient hospital services. They are often the single largest employer in the area and they help to attract primary care physicians who want to be assured that they have access to necessary specialized equipment and staff. In some areas of the United States, the small rural hospital provides the only health care in the area. In these cases, potential patients would be forced to travel long distances, which can prove impossible considering the lack of transportation services in rural communities.

In an attempt to strengthen the rural hospital system, hospitals are diversifying their services to improve access and delivery of healthcare. Some rural hospitals are converting a number of post-acute beds to increase out-patient and social services. Other hospitals are entering into multihospital arrangements to help ease their financial strains. These arrangements can include affiliations, shared services, consortium arrangements, contract management, leases, corporate ownership with separate management, and complete ownership. The advantages of joining such arrangements include cost savings from joint purchasing and shared services, certain operating advantages such as increased productivity and lower staffing requirements, and improved access to capital resulting in lower interest costs.[23]

There are a number of features of PPS which have been identified as having an effect on rural hospitals, including the urban/rural DRG payment differential, the wage index adjustment, payments for outlier cases, and the special provisions for sole community providers, referral centers, and hospitals serving a disproportionate share of the poor patients. Of primary importance to all hospitals (and particularly rural hospitals) has been the amount of increase Congress authorizes to PPS hospitals. This increase, known as the update factor, is discussed in greater detail in the next section.

A number of important provisions were included in the final OBRA 1989 package that addressed congressional concerns with regard to rural hospitals. These provisions include: (1) Setting a higher PPS update factor for rural hospitals than for urban hospitals, (2) liberalizing the criteria for classifying hospitals as sole community hospitals, a status which qualifies institutions to special treatment under PPS, (3) extending the status of current referral centers for 3 additional years, including all hospitals classified as referral centers before October 1, 1989, (4) requiring the Secretary to establish a Geographical Review Board for hospitals to direct appeals for a change in classification from rural to urban, or from one urban area to another urban area, (5) requiring the Secretary to develop a proposed phase-out plan of the urban-rural differential, (6) permitting small rural hospitals classified as Medicare-dependent, caseloads consisting of 60 percent or more Medicare beneficiaries, to receive payment based on the sole community hospital reimbursement schedule, and (7) increasing rural health care transition grants to $25 million for fiscal year 1990 and allowing these grants to be awarded for telecommunications projects.

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[23] Rural Hospitals and Medicare's PPS, Background Paper, Prepared for the Use of the Members of the Committee on Finance, May 1986.

In 1989, the Senate Special Committee on Aging held field hearings to address issues in rural health care. (See supplemental material for additional information on hearing summaries.) Access to health care, inadequate professional staff, and long-term health care financing prevailed as the major concerns of the elderly in rural America. Currently the elderly account for approximately 25 percent of the rural population. This increases the burden on the rural health care system. This burden is exemplified by increasing numbers of hospital closings, inadequate Medicare reimbursement rates (12.3 percent lower than for urban hospitals), and difficulty in attracting and retaining professional health care providers.

In 1988, 40 rural hospitals were forced to close and as many as 600 face the propsect of closure in the next few years. The average small rural hospital (fewer than 50 beds) is losing money; only 27 percent of the small rural hospitals were breaking even or realizing a profit from patient revenues in 1986. Currently, Medicare reimbursement policies do not adequately meet qualification thresholds for assistance on unusually high cost cases ("outlier" cases), revenue "losers" which are much more difficult for small hospitals to absorb. Furthermore, these policies fail to recognize the vulnerability of low-volume small rural hospitals to a payment system which leaves them at complete risk for fluctuations in admissions and costs.

In addition to the Medicare reimbursement policies, the inadequate numbers of physicians and other health professionals add to the rural health care challenge. The recruitment and retention of physicians into the rural hospital setting is a complex situation involving a great many factors, such as lifestyle, spousal satisfaction, access to new technologies, and specialty back up, and of course, reimbursement. Although the supply of physicians continues to grow nationally, the isolated and poor rural areas continue to have difficulty attracting new physicians.

The importance of hospitals that are their community's sole source of care or are so-called "frontier" hospials is strongly suggested by a recent study of rural residents which found that, largely because of limited resources and access to transportation, only 31 percent of those under age 75 crossed a county line to obtain needed medical care; moreover, a mere 18 percent of those over 75 left their home counties for care. DHHS has yet to provide Congress with needed and timely data on what role Medicare and other Federal health care policy decisions have played in terms of maintaining or improving access to medical care in rural areas.

The testimony of expert witnesses in the 1989 hearings resulted in a number of recommendations regarding the current problems facing the rural health care system. The policy recommendations include changes that would: (1) Implement a resource-based physician reimbursement system, thus eliminating the urban/rural differential, (2) create an optional cost-based reimbursement system for rural hospitals with less than 50 beds, (3) develop a hardship fund for hospitals of 50 beds or less that are essential to their community and have a high percentage of Medicare admissions, (4) expand the National Health Services Corps and increase Federal funding subsidies for physician extenders and nursing education, and (5) define and ensure an orderly and well-planned transition for those rural hospitals that must close. This transition should include an alternative that would ensure that the professional, technical, and transportation components of health care will continue to be available within the community.

(c) Transition to national rates and increasing DRG payments

Under PPS, hospitals are paid a predetermined rate based on a physician's diagnosis rather than the former cost-based reimbursement system. Medicare-eligible hospital inpatients are classified into 1 of 470 DRG's, which are based on the patient's diagnosis. DRGs represent the national average cost per case for treating a patient with that particular diagnosis. These rates are adjusted to account for differences in hospital wage levels. The national PPS payment rates were phased in over a 4-year period, which was completed in fiscal year 1988. During the transition period, payment rates were based in part on historical, hospital-specific costs and in part on the Federal DRG payment amount. Payments are now based on the Federal DRG amount, with no hospital-specific component. In most areas, the Federal amount is a fully national rate. Although in a few regions with historically higher costs, the Federal amounts will be based in part on regional rates until September 30, 1990. This final transition provision is known as the regional floor.

To determine the total payment to a hospital for a particular DRG, the applicable Federal payment amount is multiplied by the relative weight for that particular DRG. Each of the approximately 470 DRG's has been assigned its own weight which reflects the relative costliness of treating a patient in that DRG compared to the average Medicare patient. OBRA 1989 includes a DRG weighting factor reduction of 1.22 percent for discharges in fiscal year 1990. This reduction is the same as one proposed by the DHHS Secretary in regulations for 1990.

Hospital payments comprise such a large share of the Medicare Program that they were again the major focus of congressional efforts to trim Medicare in 1989. However, authorizing committees, sensitive to the growing financial concerns of hospitals (particularly rural hospitals), tried to provide as large a PPS update factor as possible for hospital payments. In addition, in an attempt to increase rural hospital reimbursement by Medicare, many Members actively supported efforts to reduce or even eliminate the urban/rural differential for reimbursement rates.

On October 16, 1989, the President issued a final sequester order under the Balanced Budget and Emergency Deficit Control Act of 1985, thus imposing a 2.1-percent reduction on total Medicare payments. OBRA 1989 extended the sequester reductions for Medicare Part A until December 31, 1989. For payments received after December 31, 1989, OBRA exempts Medicare Part A services from the continuing governmentwide sequester imposed for the remainder of fiscal year 1990. The net increases in basic inpatient payment rates, effective at the expiration of the temporary sequester on Jaunary 1, 1990, are as follows: 4.4 percent for large urban hospitals, 3.75 percent for other urban hospitals, and 8.5 percent for rural hospitals. For fiscal year 1990 and all subsequent years, current law provides that the update factor is to be set equal to the market basket index, with no adjustments.

(d) Capital reform

Capital payment to hospitals continues to be exempted from the PPS. Under current law, hospitals are reimbursed on a retrospective cost basis for their expenditures for equipment and facilities, incuding rental, interest, insurance, and depreciation costs, and a return on equity. The passthrough of capital costs has encouraged hospitals to make capital investments, whether or not those investments are justified in terms of the needs of their communities. Moreover, as ProPAC has noted, the passthrough encourages early retirement of assets, promotes insensitivity to interest rates and financing methods, and favors the use of capital over labor resources. In 1984, Medicare paid about $3.2 billion for capital-related costs.

In establishing PPS with the enactment of the Social Security Amendments of 1983 (P.L. 98-21), the DHHS Secretary was originally authorized to develop a method for including capital costs in PPS. Repeatedly though, Congress has postponed this authority. OBRA 1987 required the Secretary to provide payment for capital-related costs in accordance with PPS, effective for hospital cost reporting periods beginning on or after October 1, 1991, and repealed the Secretary's authority to establish prospective payments for capital before that date.

As the debate to establish PPS rates for capital cost reimbursement continues, Medicare has been paying a rate based on a reduced share of the actual capital costs. OBRA 1989 extends the 15 percent capital-related reduction (established by OBRA 1987) for portions of cost reporting periods or discharges occurring beginning on January 1, 1990, and continuing through the remainder of fiscal year 1990. Hospitals received 100 percent of capital costs, subject to the Gramm-Rudman-Hollings budget sequester reduction of 2.1 percent, for the period between October 1, 1989 and December 31, 1989. The current administration advocates continued reductions for capital reimbursement because, under the reasonable cost system, hospitals have no incentive to control facility and equipment expenditures.

(e) Periodic interim payment (PIP)/prompt pay issues

Those who provide services to Medicare beneficiaries are reimbursed through fiscal intermediaries and carriers. These entities, usually insurance companies such as Blue Cross and Blue Shield, contract with Medicare to handle claims processing, auditing, payment safeguards, and other such responsibilities. Congress approves an annual budget for HCFA to administer the Medicare Program which includes within it funds for the carriers and fiscal intermediaries. In recent years, the administrative budget has been tightly controlled as part of efforts to hold down Medicare expenditures.

In response to this situation, Medicare contractors reduced service levels to providers and beneficiaries, claiming that they were receiving inadequate payment to perform the increasing volume and scope of work. Consequently, it is taking more time to process claims and to respond to inquiries.

During 1986, DHHS took steps to institutionalize a slow-down in the processing of Medicare payments with the intention of making significant savings in the health care program. Medicare contractors, providers, and Members of Congress responded with vehement opposition to the proposal and the Department recanted. However, the final budget action for fiscal year 1987 included a provision which set minimum standards for timeliness of claims processing: 95 percent of clean claims in fiscal year 1987 were to be paid in not more than 30 days, reduced to 26, 25, and 24 days in subsequent fiscal years.

Prior to fiscal year 1987, DHHS regulations allowed for biweekly periodic interim payments (PIP) to providers. These payments were based on the providers projected annual costs divided into 26 equal amounts. Hospitals, home health agencies, and skilled nursing facilities meeting certain criteria were entitled to receive payments on this basis. Under legislative action during 1986, PIP was eliminated for all PPS hospitals with the exception of rural hospitals of 100 beds or less and certain disproportionate share hospitals (hospitals which have a disproportionate share of low income patients). PIP was to be continued in cases where a hospital could demonstrate it was experiencing significant cash-flow difficulties resulting from operations of the intermediary or from unusual circumstances of the hospital's operation.

OBRA 1987 included several changes in claims processing. As an alternative to achieving deficit reduction savings through lengthening the Medicare claim payment process (as recommended by House budget action), the law instead set a "payment floor," an initial processing period during which claims must be held without payment (a proposal forwarded by the Senate). The payment floor was set at 10 days for the 3-month period beginning July 1, 1988, and 14 days for 1 year beginning October 1, 1988. The legislation prohibits the Secretary of DHHS from taking other steps with the specific goal of slowing claims processing or delaying claims payments. In an attempt to reduce the deficit, the Senate proposed elimination of PIP for disproportionate share hospitals. However, this proposal was dropped in the joint Senate/House conference and not included in the OBRA 1987.

OBRA 1989 developed merged hospital guidelines with respect to PIP. In the case of hospitals eligible for PIP that merge with another hospital, the merged hospital would continue to receive PIP payments if the new entity met the disproportionate share adjustment threshold for PIP payments after the merger.

(f) Medical education

Since its enactment in 1965, Medicare has reimbursed hospitals for its share of the direct costs of approved health professions education programs conducted in hospitals. These direct costs include: (1) Salaries and fringe benefits for residents, faculty, and support staff, (2) the cost of conference and classroom space in the hospital, (3) any costs of additional equipment and supplies, and (4) allocated overhead costs. Physician graduate medical education (residency training) is the most costly component of health professions education paid under Medicare.[24] In addition, Medicare pays teaching hospitals an additional amount, called the indirect adjustment, to cover factors (including indirect teaching costs such as additional tests ordered by residents) that are believed to result in higher costs in teaching hospitals than in nonteaching hospitals.

When the Medicare Program was established, Congress made clear its intent that Medicare should support the clinical training of health personnel at least until alternative community-based systems of support were developed. As a result of Medicare payment policies as well as additional Federal support of the health professions through the National Institutes of Health and Title VII of the Public Health Service Act, as a vast network of medical and health profession schools developed throughout the country.

The resulting growth in medical education has helped ease what was once a substantial physician shortage to the point where many now argue that we are in danger of having too many physicians by the end of the decade. However, while in the aggregate there may be an excessive amount of physicians, a physician shortage is expected to exist for certain specialty areas such as psychiatry and primary care specialists. Additionally, there is also evidence that there remain a large number of medically underserved areas in the Nation, indicating that excess supply does not directly alleviate maldistribution problems, especially in poor inner-city neighborhoods and remote rural areas.

Under the 1983 PPS legislation, Congress doubled the indirect medical education adjustment in order to counteract the potential negative impact that PPS was expected to have on teaching hospitals. Within a few years, claims were made that reimbursement for both direct and indirect medical education under Medicare was excessive, and that reductions were warranted. Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Congress established a PPS for the direct costs of medical education. Payment is based on each hospital's average cost per resident and on the number of years of training provided to residents. COBRA also reduced the indirect medical education adjustment factor to approximately 8.1 percent from May 1, 1986, to October 1, 1989. This adjustment is applied on a curvilinear basis, meaning the payment would not necessarily increase in direct proportion to the ratio of interns and residents to bed size. The Congress also provided for a temporary adjustment for hospitals with large percentage of low-income Medicare and Medicaid patients. This adjustment was financed by the reduction in the teaching adjustment.

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[24] U.S. Library of Congress, CRS, Background Paper for use of the Members of the Senate Finance Committee on Payments for Medical Education by the Medicare Program. Washington, DC, May 1985.

DHHS issued final regulations implementing the COBRA payment changes for graduate medical education costs on September 29, 1989. These changes are effective retroactively to 1985. Retroactive adjustments for interim direct medical education payments made between July 1, 1985, and the date of the final rule are estimated to save Medicare $440 million.

The primary related development in OBRA 1986 was a provision which reimbursed under Medicare all the time a resident spends in patient care activities, regardless of the setting. This change encourages training in primary and long-term care, and eliminates the disincentive to train in certain outpatient settings. To further control costs and reduce the Federal deficit, OBRA 1987 reduced the indirect medical education adjustment to approximately 7.7 percent, effective for hospital discharges occurring on or after October 1, 1988, and before October 1, 1995. The disproportionate share payment is scheduled to expire after October 1, 1995, at which time the adjustment increase would be approximately 8.3 percent.

The administration's fiscal year 1990 budget proposed to reduce the adjustment factor from 7.7 percent to 4.05 percent. Both DHHS and GAO made similar proposals based on the argument that this lower amount more accurately reflects the estimated effect of teaching programs on a hospital's costs. The Senate's fiscal year 1990 reconciliation proposal included a reduction in the indirect medical education adjustment to an average of 7.1 percent for each 0.1 percent increase in the hospital's ratio of interns to residents. This Senate proposal, however, was not included in OBRA 1989.

(g) Uncompensated care

The public-private patchwork of health insurance coverage has traditionally afforded basic protection to a majority of Americans. However, today there are between 31 and 37 million Americans who find themselves without health insurance. Approximately 17.5 percent of the population under 65 is uninsured. According to the March 1988 current population survey, 31.1 million Americans are uninsured, or 12.9 percent of the total population. Of these, 9.2 million are 35–64 years of age. (Moger, M. Eugene, A Revised Look at the Number of Uninsured Americans. Health Affairs, summer 1989, pp. 102–110.) Surprisingly, 300,000 persons over the age of 65 are without insurance of any kind even though the common perception is that all the elderly are taken care of by Medicare and Medicaid.[25]

The number of proportion of the uninsured is increasing substantially. By some estimates, the number of uninsured nonaged persons, the only group for which trend data are currently available, increased by over 20 percent from 1979 to 1986.

Prior to the last recession, the problem of the uninsured was viewed as a problem of the very poor, and those individuals who had seasonal, part-time, or low-skilled jobs, in which employers generally did not provide health insurance coverage. Today, more than 80 percent of the uninsured population is employed or lives in families of workers.

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[25] U.S. Congress, Senate Special Committee on Aging. Americans at Risk: The Case of the Medically Uninsured. Background paper prepared by the staff. Washington, DC, June 27, 1985.

During the last recession, 10.7 million Americans lost their health insurance. These people lost vital protection when they or their family's head of household lost their jobs. Since that time, the system of health care protection has changed radically. Cutbacks in Medicaid and other public programs have reduced some of the sources of funding which formerly helped to subsidize health care for America's uninsured. In additon, the changing nature of the better care market, with reforms in reimbursement, heightened competition, and the growth of for-profit medicine, is making it increasingly difficult for the uninsured and the underinsured to obtain even emergency access to health care.

Before prospective payment, many hospitals were able to shift the burden of providing high levels of uncompensated care to Medicare and other payers, such as Blue Cross. Under PPS and the continued reduction of Federal payments, as well as tightening reimbursement policies among private payers, hospitals are increasingly reluctant to take patients for whom there is no guarantee of reimbursement. The shrinking number of hospitals that take large numbers of low-income patients argue that such patients are generally sicker and require greater intensity of services. To the extent that these hospitals are bearing a disproportionate burden of such patients, they assert that they should be receiving a reimbursement which reflects this special burden.

Disproportionate share hospitals.—Legislation addressing DSH's was first enacted as a provision in the Tax Equity and Fiscal Responsibility Act of 1982. The Secretary of DHHS was required to provide for exemptions from, and adjustments to, the cost limits then in effect for Medicare reimbursement to hospitals. HCFA did not implement the provision because, as was indicated in regulations, it did not have the data to determine the extent to which special consideration for such hospitals was warranted or the type of provision that might be appropriate. A similar provision for DSHs was included in the Social Security Act Amendments of 1983. Under this act, the Secretary was charged with developing a methodology for a DSH adjustment to the DRG's. Again, HCFA indicated in regulations that it would not implement the provision in fiscal year 1984 or fiscal year 1985 because it did not believe that it had the evidence to justify the adjustment. In the Deficit Reduction Act of 1984, Congress required the Secretary to develop a definition of DSH's and to identify such hospitals by the end of 1984, which it failed to do.

The special needs of DSH's have been the subject of much debate and have greatly influenced congressional action on a number of issues related to Medicare hospital reimbursement. Special needs could be interpreted to include a broad array of special problems found in hospitals serving low-income or Medicare patients, ranging from potentially higher costs of treating patients that are more severely ill to the cost of providing uncompensated care. Generally, they have been interpreted more narrowly. Thus, the costs of additional services and more costly services that may be required to meet the needs of low-income or Medicare patients would be included only to the extent that such costs result in higher Medicare operating costs per case in hospitals serving disproportionate numbers of such patients. Moreover, additional payments to hospitals under Medicare for such costs as uncompensated care have been excluded, usually on the grounds that Section 1861(v) of the Social Security Act specifically prohibits Medicare from paying for the cost of services provided to persons not entitled to benefits under the program.[26]

In 1985, ProPAC recommended that a DSH provision be included in fiscal year 1986 PPS rates.[27] Armed with this recommendation, and frustrated by HCFA's inaction, the House Ways and Means Committee decided to develop its own adjustment, and included a provision in its deficit reduction package. In response to a court order from the U.S. District Court for the Northern District of California, resulting from the lawsuit of a small California rural hospital, HCFA published proposed rules implementing the DSH provision on July 1, 1985. However, HCFA made clear that it would award such an adjustment only in extraordinary cases and only after a case-by-case review.

The 1985 budget reconciliation package (OBRA) required that the disproportionate share adjustment be applied to the Federal portion of the DRG rate for hospitals with a relatively high percentage of low-income patients. Urban hospitals with at least 100 beds receive a graduated adjustment from 2.5 to 15 percent, if their disproportionate patient percentage is at least 15 percent. Smaller urban hospitals receive an adjustment of 5 percent if their disproportionate patient percenage is at least 40 percent. Rural hospitals receive an adjustment of 4 percent if their disproportionate patient percentage is at least 45 percent. The adjustment applies to all discharges after April 30, 1986, and before October 1, 1988.

OBRA 1989 increased the Federal portion of the DSH's reimbursement rate for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, by 2.5 percent plus 60 percent of the difference between 15 percent and the hospital's disproportionate patient percentage. Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds that have a disproportionate patient percentage of over 20.2 percent receive a further increase in the adjustment. Hospitals with more than 20.2 percent low-income patients, the payment adjustment is increased by 5.62 percent plus 65 percent of the difference between 20.2 percent and the hospital's percentage of low-income patients. Public Law 100-647, the Technical and Miscellaneous Revenue Act of 1988 continues disproportionate share payments through September 30, 1995.

(h) Area wage index

The area wage index is an important element used in the calculation of DRG payments to hospitals. The wage index was developed to ensure that the DRG payments reflect differences in wages from area to area. To compute the initial wage index, HCFA used hospital wage and employment data maintained by the Bureau of Labor Statistics (BLS) of the Department of Labor. However, it is generally recognized that this data base does not accurately reflect differences among hospitals. The principal limitation of the BLS data—their inability to recognize local differences in the number of part-time workers—was cited by a large number of hospitals, particularly rural midwestern facilities.[28] Under the Deficit Reduction Act of 1984, HCFA was required to report to Congress on a refined wage index which was to be implemented retroactive to October 1983. In 1984, HCFA attempted to obtain better data on wage differences through a survey of hospitals, but the survey was hampered by a low response rate and questionable data quality.

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[26] U.S. Library of Congress, CRS. Medicare Payment Provisions for Disproportionate Share Hospitals. Background paper. Prepared for the use of the Members of the Committee on Finance, Washington, DC, July 1985.

[27] U.S. DHHS, Prospective Payment Assessment Commission, report and recommendations to the Secretary. Washington, DC, April 1, 1985.

The required report,[29] which was released to Congress in 1985, proposed two alternatives. One wage index was derived from total gross hospital wages, which included salaries and wages for contracted labor, interns, and residents, personnel employed in nonhospital cost centers, and hospital-based physicians. The other index excluded several variables from its calculation and was referred to as the adjusted gross index. Later that year, HCFA implemented a new wage index for discharges based on the gross wage data from HCFA's 1984 survey. The rule also provided that the retroactivity required by current law would not come into effect until 1986. This was done to allow time for Congress to reverse the retroactive provision and for HCFA to develop a method to identify retroactive amounts.

In 1986, HCFA implemented a revised wage index, based on 1982 HCFA data which reflected the total hours of employment rather than the number of employees. This wage index was continued into 1987 with minor changes.

In 1987, ProPAC recommended that the Secretary of DHHS update the hospital wage data on a regular basis in order to ensure that most accurate wage index possible, and that the data include wage and hour employment information for hospital occupational categories.[30] In September 1987, HCFA published final rules for the Medicare inpatient hospital prospective payment system for fiscal year 1988 which changed the method of computing the national average wage level for use in determining the area wage index. In addition, the regulations adopt a blended wage index which uses a combination of 1982 and 1984 data. These changes resulted in a lower wage index value for all areas relative to the national rate; however, the payment rates were adjusted so that the new index would have no effect on total PPS payments.

(4) Issues Affecting Physicians

(a) Physician expenditures under Medicare

Part B supplemental medical insurance (SMI) of the Medicare Program has experienced tremendous growth since its inception, in terms of both services delivered and program expenditures. Between fiscal year 1978 and 1987, Medicare spending for physicians' services increased at an average annual rate of 16 percent. SMI accounts for about one-third of total Medicare spending, and physician services make up about 75 percent of SMI expenditures. Although their services comprise less than 25 percent of all Medicare spending, physicians actually may influence more than 70 percent of other medical services used by Medicare beneficiaries.[31]

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[28] DHHS, HCFA, Report to Congress on the Hospital Wage Index as required by Section 2316(a) of the Public Law 98-369, Washington, DC, March 28, 1985

[29] Ibid.

[30] ProPAC, report and recommendations to the Secretary, DHHS, April 1, 1987

Between 1980 and 1983, Medicare expenditures for physician services increased at an average annual rate (adjusted for inflation) of 12 percent, compared to 6.5 percent for all physician expenditures.[32] In response, Congress froze Medicare fees for participating physicians from 1984 to 1986; the fee freeze was lifted in December 1986 for nonparticipating physicians. The freeze was a qualified success. While the average annual increase in Medicare expenditures for physician services was lower between 1983 and 1986 (9.1 percent) than in previous years, it nonetheless was higher than the annual increase of 7.2 percent for all physician expenditures. This suggests to some policymakers that physicians may be increasing the volume of procedures and visits provided to Medicare beneficiaries to make up for the loss of income that they may have experienced as a result of the fee freeze.

OBRA 1989 provides for a continuation of the 2.1 percent reduction in Medicare payments to physicians that was initially put into place through the Gramm-Rudman sequestration process. The reduction will continue through March 31, 1990. A 1.42 percent sequester will remain in effect for the balance of the year. Also, OBRA 1989 delays the 1990 update until April 1, 1990 (except for ambulance services and clinical lab services) and specifies that the MEI 1990 update for radiology, anesthesiology, and overpriced procedures is zero. The update is 2 percent for all other services, except primary care services, which will receive a full MEI update.

(b) Physician payment reform

From 1984-87 Congress made a number of legislative adjustments to the way Medicare pays physicians. Despite the adjustments, the physician payment system remained relatively intact, with payments made for each service rendered. These adjustments, designed to stem the dramatic expenditure increases within Part B, were not successful in slowing the increases.

These increases have been the focus of a great deal of attention. Many have suggested that both the individual prices and the unit of payment are inflationary and create price distortions. Others believe that these imbalances created financial incentives that inappropriately influence physicians' decisions about what services to provide, location of their practices, and specialty choice. The Aging Committee released a report in 1988 entitled "Medicare Physician Payment Reform: Issues and Options." This report provides an overview of the current system, as well as options for change to physician payment under Medicare.

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[31] Physician Payment Review Commission. Medicare Physician Payment: An Agenda for Reform. Washington, U.S. Govt. Print. Office, 1987, p.13.

[32] Anderson, Gerald F. and Jane E. Erickson. National Medical Care Spending. Health Affairs, v. 6, no. 3, fall, 1987. p. 101.

As part of OBRA 1989, the Congress established a new payment system for physician services paid for by Medicare. Most view the physician payment reform package as the most significant health care legislation enacted in 1989. Given very little chance of passage in 1989—because of both the magnitude of the reforms and the dominance of the budget reduction debate during reconciliation deliberations—it is hailed as a major accomplishment of the 101st Congress. Its success clearly reflected the work of Senators Rockefeller and Durenberger, as well as Congressmen Stark and Waxman, who pushed hard for enactment in 1989. The administration's support was also crucial to the reform's success.

Under the new system, payments will be made under a fee schedule based on a relative value scale (RVS). An RVS is a method of valuing individual services in relationship to each other. Also included in the new system are annual volume performance standards which are target rates of increase in physician expenditures.

Background.—For several years, Congress and the administration explored a number of options for reforming the physician payment mechanism under Medicare. In 1986, legislation was enacted that required the Secretary, with the advise of the newly established Physician Payment Review Commission (PPRC) to develop a RVS. DHHS made an agreement with the Harvard School of Public Health to develop a resource-based RVS (RBRVS). William Hsiao was the principle investigator, and the AMA was a subcontractor. The "Hsiao report," presenting the results of phase I of the study, was released in September 1988.

In 1989, the PPRC released a report containing recommendations for reforms to the physician payment system. A major recommendation was the establishment of a Medicare fee schedule based on an RVS. This recommendation was based largely on the Hsiao report, although some modifications were suggested. The PPRC, the administration, and others were concerned that the use of an RVS alone would not control physician expenditures. These concerns stemmed from the fact that an RVS, by itself, does not impose limitations on the volume of services. Volume was a concern because, from fiscal year 1978 to fiscal year 1987, 45 percent of the average annual rate of increase in spending for physicians' services were attributable to increases in the volume and intensity of services. Thus, PPRC recommended the use of a national expenditure target (ET). With this target, if total physician expenditures in a year exceeded the ET, the conversion factor in the subsequent year would be reduced.

Many interest groups, including physician groups, supported the concept of the RBRVS. Numerous concerns were raised regarding the construction of the fee schedule. However, the most controversial component of the PPRC report was the recommendation for the use of an expenditure target. The PPRC characterized the target as a means of encouraging the physician community to respond with practice guidelines and other mechanisms to encourage appropriate delivery patterns. Also, proponents of the ET felt that an overall spending limit was needed, given the uncertainty surrounding the likely changes in volume and mix of services resulting from implementation of an RVS. Opponents of the expenditure target characterized the ET as a means of limiting Medicare expenditures, suggesting that a target set in this manner might not fully cover costs that they feel are reasonable and necessary to meet the health care needs of the elderly. Some opponents argued that physicians may respond to such incentives by rationing care.

Fee schedule.—Beginning in January 1992, each year the Secretary is required to establish a fee schedule, which establishes payment amounts for all physicians' services provided in all fee scheduled areas for the year. The law provides for a transition to the fee schedule from 1992-96. The fee schedule amount for a service is equal to the product of: (1) The relative value for the service; (2) the conversion factor for the year; and (3) the geographic adjustment factor for the service in the fee schedule area.

The relative value for each service has three components. The work component is the portion of the resources used that reflects physician time and intensity including activities before and after patient contact. The practice expense component is the portion of the resources used in furnishing the service that reflects the general categories of practice expenses, such as office rent and wages of personnel. The term includes all expenses, excluding malpractice expenses, physician compensation, and physician fringe benefits. The malpractice component is the portion of resources used reflecting malpractice expenses. The Secretary is to develop a method for combining the relative values determined for each component for each service in order to produce a single relative value for the service. And, the Secretary is required to update the relative values at least every 5 years to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary is required to consult with the PPRC and physician organizations in making updates.

The conversion factor is another component of the fee schedule. The conversion factor for each year is the previous year's conversion factor adjusted by the update for that year. By April 15 each year (beginning in 1991), the Secretary is required to report recommendations to the Congress on the appropriate update in the conversion factor for all physician services for the following year. After PPRC review, Congress is expected to specify the update. In the absence of congressional action, a uniform default update is to be applied for all services.

The third component of the fee schedule is the geographic adjustment factor for the service for the area. This adjustment factor takes into account practice expense, malpractice expense, and physician work effort in each of the different fee schedule areas compared to the national average.

Medicare volume performance standard rates of increase.—Each year a volume performance standard rate of growth is established for physicians service under Medicare. Services included in the standard are all physician services, other items and services commonly furnished in physician offices such as clinical diagnostic laboratory tests, or services commonly performed by physicians. The new law specifies the following factors that must be included in the calculation of the standard for fiscal year 1990: Inflation, growth in the beneficiary population, historical changes in the volume and intensity of services, and a performance standard. In subsequent years, the Secretary is to recommend a standard to Congress, and the PPRC is to comment on the recommendation. Congress is expected to specify the standard. In the absence of congressional action, a default performance standard will be used.

Limitation on beneficiary liability.—The new physician payment legislation establishes new limits on extra billing charges by nonparticipating physicians. The new limits are set at a maximum percentage above the recognized payment amount for nonparticipating physicians. In 1991, the limit is 125 percent. Each year the limit will be reduced by 5 percent, until it reaches 115 percent in 1993. For subsequent years, the limiting charge is 115 percent of the recognized payment amount for nonparticipating physicians for the year. Also, the new law requires physicians to accept assignment on all claims for persons who are dually eligible for Medicare and Medicaid.

Monitoring.—The Secretary is required to monitor actual charges of nonparticipating physicians after January 1, 1991. Also, the Secretary is to monitor and report to Congress on any changes in the proportion of services provided by participating physicians, the proportion of services paid on assignment, and the amounts charged above recognized payment amounts. If the Secretary finds a significant reduction in participation or assignment rates or an increase in balance billing charges, he is required to develop a plan to address the problem and submit recommendations to Congress. The Secretary is also required to monitor: Changes in utilization and access within geographic, population, and service-related categories; possible sources of inappropriate utilization which contribute to the overall expenditure level; and factors underlying these changes and their interrelationship.

Outcomes and effectiveness research.—The Agency for Health Care Policy and Research was created by OBRA 1989. One function of this agency, which will have impact on the implementation of physician payment reform, is to coordinate and expand the outcomes and effectiveness research program. This program promotes research with respect to patient outcomes for selected medical treatments and surgical procedures for purposes of assessing their appropriateness, necessity, and effectiveness.

Impact.—Simulations of the fee schedule suggest that Medicare payments would, on average, increase for medical specialties and decrease for surgical specialties. Also, the fee schedule is expected to change the distribution of payments among geographic areas with physicians in urban areas facing reductions in payments and those in rural areas generally receiving more.

(d) Other physician payment issues

OBRA 1989 contained several other provisions that affect physicians and physician reimbursement under Medicare. The reconciliation bill includes provisions on payment ceilings for specialty-specific prevailing charges and customary charges for new physicians. The administration's proposal on prevailing charge limits on services performed by more than one specialty was narrowed so that it applies only to surgery, radiology, and diagnostic physicians' services. The current law provision limiting new physicians' customary charges to 80 percent of the prevailing charge in the first year of practice was maintained. The administration's proposal to limit the customary charges of new physicians to 85 percent of the prevailing charge in the second year was adopted. Another provision maintains current law limits on maximum allowable charges in 1990 and phases in new limits over a 3-year period. In 1991, the limit is equal to the same percentage difference by which a physician's actual charge exceeded the prevailing charge for the service, up to a maximum of 25 percent.

Also, OBRA 1989 contains a provision which prohibits physicians from profiting by referring patients to clinical laboratories in which they have invested. Starting January 1, 1992, physicians are prohibited from referring patients to clinical laboratories in which they have a financial interest. Exemptions from this provision are granted to some types of facilities, including hospital ownership, rural providers, and group practices. Medicare providers will be subject to new reporting requirements regarding ownership, including a requirement that entitles report on the ownership arrangements employed and the names and provider numbers of all the physician investors.

(5) Issues Affecting Medicare HMO's

The participation of HMO's in the Medicare Program represents yet another attempt by the Federal Government to stem rising health care costs. Like all health cost containment strategies, the challenge facing the Medicare HMO program is to achieve this objective without compromising health care quality. In 1988, Congress rewrote legislation originally enacted in 1973 and produced the Health Maintenance Organization Amendments of 1988 (P.L. 100-517). OBRA 1989 also contained provisions addressing problems related to post-contract protection of Medicare beneficiaries against non-Medicare covered health costs, quality of care, and HMO capitation rates.

(a) The HMO amendments of 1988

Congress spent 2 years rewriting the 1973 HMO Act to ease restrictions on HMO's and on employers who purchase HMO coverage. Prior to the passage of this law, HMO's were required to use the community rating to set their prices. Under the new HMO Amendments, plans can calculate their premiums according to expected utilization, or a modified experience rating. However, if the projection of expected utilization proves incorrect, no adjustments will be allowed. HMO's must also make publicly available the data they use in determining premiums.

The HMO amendments repeal the requirement that employers make equal contributions to HMO's and traditional indemnity insurance plans when they offer their employees a choice of insurance options. Instead, firms are barred from financially discriminating against one type of insurance coverage. Premiums charged for indemnity coverage cannot exceed HMO premiums by more than 10 percent where the number of workers involved is less than 100. Finally, as of October 1, 1995, employers will no longer be required to offer employees a choice of HMO or indemnity coverage.

(b) Post-contract protection

An attractive feature of many HMO's is the availability of health care coverage which is more generous than that provided under the combination of Medicare and most supplemental, or medigap, insurance policies. Accordingly, many beneficiaries join HMO's as an alternative to traditional medigap policies. However, if an HMO closes or ceases participation in the Medicare Program, a beneficiary may be left facing unanticipated, uncovered health costs. This is particularly the case for the beneficiary who cannot find an alternative medigap policy for the HMO coverage that does not exclude, as most such policies do, existing medical conditions for a period of several months. As a result, a participant of an HMO which has closed may be left totally vulnerable to non-Medicare covered health care costs.

In 1987, two events highlighted this potential problem. First, the Florida-based International Medical Corporation, Inc. (IMC), one of the Nation's largest HMO's with about 150,000 Medicare beneficiaries, declared bankruptcy. Second, 29 Medicare HMO's—18 percent of the total—pulled out of the Medicare HMO program.

In the case of IMC, another health care corporation assumed responsibility for providing roughly similar services to the IMC enrollees. This arrangement prevented Medicare enrollees from suffering any adverse financial consequences arising from lack of supplemental health insurance. With respect to the HMO withdrawals from the Medicare Program, few beneficiaries were involved due to the small size of the contracts in question.

Nevertheless, both of these events drove home the point that Medicare enrollees in an HMO are at some risk of sudden supplemental health care costs. To guard against this, Congress included provisions in OBRA 1987 requiring HMO's to ensure that Medicare enrollees are provided with supplemental coverage in the event the HMO ceases to serve such beneficiaries. Additional provisions required HMO's to inform Medicare enrollees of the possibility that its Medicare contract may be cancelled at some future time.

(c) Quality of care

To prevent wrongful practices among HMO's, Congress included provisions in OBRA 1987 to broaden and increase monetary sanctions against HMO's which selectively deny enrollment to a Medicare beneficiary or health care to a Medicare enrollee. A penalty of up to $100,000 was established for engaging in biased enrollment, and existing fines were increased from $10,000 to $215,000 for denying a beneficiary medically necessary services. Similar sanctions were set for charging premiums in excess of the legal amount, involuntarily disenrolling or refusing to re-enroll a beneficiary on the basis of health status.

The 1987 reconciliation legislation also delayed by 1 year the effective date of the prohibition against so-called incentive payments. HMO management often provides such payments to physicians as a way to reduce utilization. Out of concern that the unrestricted use of incentive payments could reduce access to health care, Congress originally had barred such practices beginning in April 1989, and mandated a DHHS report on acceptable incentive payment systems. OBRA 1989 delayed the effective date of the prohibition against the incentive payments for another year.

(d) HMO-capitation rates

A continuing controversy in the Medicare HMO program surrounds the capitation rates used to determine the prospective payments a risk-contract HMO receives. The formula for such rates, referred to as the average adjusted per capita cost (AAPCC), accounts for a number of variables, including beneficiary age and sex and the location of the HMO. Rates can vary dramatically, and HMO's can receive widely differing payments. This and other related problems have led many to criticize the AAPCC. OBRA 1989 requires DHHS to publish an explanation of the methodology and assumptions used to calculate the AAPCC for HMO's.

In light of the urgent need to hold down Medicare costs, the Medicare HMO program holds the promise of providing cost-effective, quality health care. Congress can be expected to continue to adjust the program to assure that cost-effectiveness is not achieved at the expense of Medicare beneficiaries.

3. PROGNOSIS

While advocates for the elderly and others were heartened by President Bush's reference to health care in his 1990 State-of-the-Union Address, the budget he submitted for fiscal year 1991 appeared to be inconsistent with his message. Specifically, he proposed a cut of $5.3 billion off of current services in the Medicare Program, most of it coming from the Medicare health care provider side of the ledger. Shortly after his budget was transmitted to Capitol Hill, many Members of Congress voiced their opinion that such a large cut was not only unfair, but would be impossible to achieve. Advocates for the elderly raised concerns that large cuts in the provider side would likely effect the quality of services delivered to beneficiaries.

As in previous years, hospitals (as the largest recipient of Medicare payments) will continue to be the focus of much of the cost-cutting debate during the fiscal year 1991 budget negotiations. The administration is again seeking large reduction in hospital capital payments, including for rural hospitals. While hospitals, as a whole, will likely absorb a significant portion of the Medicare cuts, there will be vigorous efforts in Congress to minimize the impact, particularly for certain segments of the hospital community. In particular, Congress can be expected to again give favorable treatment to financially vulnerable hospitals, such as those in rural settings and in inner cities.

There is also likely to be spirited debate over the Bush Administration's proposals to make further reductions in Medicare Part B reimbursement for certain physicians, and procedures deemed to be overpriced. This is viewed by the medical community, and by others, as unfair in light of the enactment of physician payment reform measures in 1989 that are to be phased in over the next several years.

The budget prognosis for 1990 is greatly complicated by the President's priority on reducing the capital gains tax, and by the debate launched at the beginning of the year over proposals to reduce the Social Security tax. If an agreement on the fiscal year 1991 budget cannot be achieved, much more severe cuts from the Gramm-Rudman budget sequester mechanisms would take place. Although Medicare is shielded from the full force of Gramm-Rudman cuts, it nevertheless would face major cuts if a sequester was ordered. Whichever budget reduction process is pursued, however, Medicare and its over 31 million beneficiaries will be directly or indirectly affected significantly by the ensuing budget cuts and program constrictions.

The first order of health policy business for the Congress in 1990, as in most of the past decade, will be to ensure that anticipated serious deficit reduction measures do not cripple the health care delivery system and the beneficiaries it serves. In an environment in which deficit reduction takes priority on the national policy agenda, the Medicare Program continues to face difficult times. As budget cuts slow down reimbursement rates for providers, pressures continue to deliver care at the lowest cost possible. Vigilant monitoring will be required to make certain that providers do not sacrifice quality care in order to reduce their costs.

Beyond the fiscal year 1991 budget, the health care policy agenda will be dominated by the lack of protection against long-term care expenses (detailed in the next chapter), and the need to address the issue of the 37 million plus Americans under the age of 65 who have no health insurance. March 1, 1990, is the deadline for the U.S. Bipartisan Commission on Comprehensive Health Care, also know as the Pepper Commission, mandated by the catastrophic health care legislation (and retained by the Medicare Catastrophic Repeal Act of 1989), to complete its work and report to Congress with recommendations on how to ensure and finance affordable and quality health coverage, including long-term care, for Americans of all ages.

The Pepper Commission consists of 12 Members of Congress, most of whom are considered Congress' experts on health care—including Senators Pryor, Heinz, and Durenberger of the Special Committee on Aging, and three public members appointed by the President. As the Commission closes in on their deadline, achieving consensus has proven to be a formidable endeavor. Nonetheless, it is expected to complete its work. It is likely that the Pepper Commission will provide a blueprint for comprehensive coverage, but one that is likely to be approached incrementally, with benefits phased in over a period of several years. Upon release of the Pepper Commission's report, it is likely that there will be numerous bills introduced and hearings conducted on the issues of access for the uninsured and long-term care.

The combination of the budget deficit and the budget debate, proposals to reduce taxes, other key priorities (e.g., clean air legislation, the drug crisis), a shortened session due to an election year, the lack of Presidential leadership, and the shadow of the 1989 catastrophic coverage debacle, virtually assure that major health legislation will not be enacted in 1990. Health care advocates, along with many Members of Congress believe, however, that the level of debate will gather momentum toward significant legislative action in the 102nd Congress.

Other health care policy issues will abound in 1990. The repeal of the Medicare Catastrophic Coverage Act was followed by large, even staggering, increases in premiums for Medicare supplemental policies—i.e., medigap. This led to a flurry of congressional activity to address this. In early 1990, Chairman Pryor announced he would conduct a hearing on medigap problems, including sales abuses. In addition, he and Senators Heinz, Kohl, and others, indicated their interest in introducing legislation to ensure that each State has the capacity to counsel and assist the elderly on their health insurance gaps and the appropriateness of their policies.

Prescription drugs will continue to receive considerable coverage in 1990. Following up on his landmark hearings in 1989, Senator Pryor will introduce legislation to ensure that State Medicaid programs are able to obtain reasonable prices for prescription drugs, as do hospitals and health maintenance organizations, from the manufacturers. This legislation, which is expected to save Medicaid several hundred million dollars, will be the subject of much debate and is likely to be heavily opposed by prescription drug manufacturers.

Other key health initiatives that will receive congressional attention in 1990 include: Efforts to reinstate some of the benefits lost in the repeal of the Medicare Catastrophic Coverage Act, such as respite care, hospice, and home health care improvements; continued emphasis on ways to protect and improve the health care delivery systems in rural America; further refinements concerning the sweeping nursing home reforms enacted in OBRA 1987; and monitoring the early stages of implementation of the physician payment reform legislation enacted in OBRA 1989.

Nonetheless, health care cost containment issues will remain the focal point of congressional consideration. The success of the health care cost containment reforms rides on the willingness of patients, providers, and regulators to get the most out of an increasingly lean system. Similarly, the success of new approaches to deal with the health care needs of the Nation depends on the ability of policymakers and advocates to develop initiatives that can either significantly alter budget priorities or offer creative, cost-effective health policy alternatives.

It should go without saying, however, the true improvements in our health care system will require strong Presidential involvement and commitment. Although President Bush has not made health care a high priority, increasing health care costs and reduced access to needed health care, along with increasing public dissatisfaction with the Nation's health care system as a whole, may force him to alter this situation.

B. HEALTH BENEFITS FOR RETIREES OF PRIVATE-SECTOR EMPLOYERS

1. OVERVIEW

Following the enactment of Medicare in the mid-1960's, the prevalence of employer-sponsored retiree health benefit packages increased dramatically. Once Medicare was established, employers could offer health benefits to their retirees with the assurance that the Federal Government would pay for many of the medical costs incurred by company retirees 65 and older. Since that time, retiree health benefits have become a common provision of private employer plans and a major source of Medicare supplemental insurance among many retirees.

At present, approximately two-thirds of the Nation's large firms offer retiree health benefits, and more than one-half promise a contribution to the costs of such coverage. Because these benefits commonly lack an adequate funding mechanism, however, retiree health plans represent large unfunded liabilities for the employer. The absence of benefit security has led to a growing concern over whether employers can meet these obligations. Such concerns are compounded by the rising costs of health care, which continue to drive up employer liabilities in this area. Should employers cut back or cancel their retiree health plans in response to these factors, many retirees stand to lose an important source of privately sponsored health insurance.

2. BACKGROUND

Many employers sponsor group health insurance plans that supplement Medicare benefits for retirees 65 and older and provide coverage for retirees not yet eligible for Medicare. Medicare, which covers more than 32 million Americans, provides fundamental health insurance for nearly all Americans 65 or older. However, Medicare neither meets all of the health care needs of these retirees, nor covers those who retire before age 65. As a result, employer-sponsored retiree health plans represent an extremely important source of health insurance protection for the Nation's retirees.

Although privately sponsored retiree health plans are far from universal, they nevertheless are included in the benefit packages offered by many employers. According to the Employee Benefit Research Institute (EBRI), 76 percent of the full-time health plan participants in 1986 had coverage continued after early retirement. Of those, 90 percent receive such coverage after reaching age 65.

The availability of retiree health coverage appears to increase with the size of a company. According to survey data collected by the Washington Business Group on Health, approximately 8 out of 10 large employers provide postretirement health coverage. In 1987, data from several surveys revealed that 42 percent of employers with 50 to 99 employees provide health benefits, and 46 percent of employers with 100 to 149 employees have such plans. These figures increase steadily with the size of the employer to 62 percent for firms with 500 to 999 employees, 77 percent for those employing 1,000 to 4,999 persons, 89 percent for firms with 5,000 to 9,999 employees, and 94 percent for firms employing more than 10,000 workers.

However, when measured against the total number of older Americans, the extent of retiree health coverage is less impressive. The National Center for Health Services Research (NCHSR) has estimated from the National Medical Expenditure Survey that only 39 percent (8.6 million) of retirees aged 55 years and older have retiree health coverage.

For those who have employer-provided coverage, retiree health benefits are very important. Just the opportunity to continue participating in the employer's group plan after retirement can represent a significant savings for a retired worker as the cost of purchasing an individual policy following retirement often is prohibitive. As a result of lower administrative costs and employer contributions, group insurance plans typically offer beneficiaries a higher range of benefits at a lower cost than are available under individual policies. For retirees under age 65, an individual plan can be extremely costly, and for those 65 or older with a pre-existing medical condition it also may be very difficult to find.

Those employers who provide coverage for retired employees and their families in a group health plan generally provide full coverage in the company's plan until age 65. At that point, most companies provide comprehensive health coverage related directly or indirectly to the benefits provided by Medicare. Under these plans, one of three approaches may be used: A "carve-out," "Medicare supplement," or "coordination of benefits" plan.

Most commonly offered to retirees is the carve-out plans. This type of health care approach provides for continued retiree coverage under a group plan, but does not cover services for which Medicare pays, thus avoiding duplicate coverage. Because retirees share their costs through copayments and deductibles, carve-out plans tend to be the least costly for employers.

Under a variation of the carve-out approach, the so-called coordination of benefits plan pays what it would in the absence of Medicare, but limits payments to 100 percent of the cost actually incurred. As this type of plan pays for services not covered by Medicare, its costs are affected by changes in Medicare coverage.

Unlike the coordination of benefits plan, a Medicare supplement type of retiree health care plan is insulated from changes in Medicare coverage by specifying exactly what costs are covered. The plan can tailor benefits to the needs of the retiree and also may result in a change in benefits when an early retiree reaches age 65. Although the costs of a Medicare supplement can be more easily controlled, this approach requires the design and administration of a separate plan.

3. Issues

(A) PROTECTION FOR RETIREES

Traditionally, employers have not prefunded health benefits, preferring instead to handle these obligations on a pay-as-you-go basis. In fact, many employers still do not appear to fully recognize the potential financial implications of their health benefit plans. Estimates of current unfunded liabilities for employee health benefits range from $100 billion, according to the Department of Labor, to $221 billion, according to the GAO. The GAO estimates that it would require $402 billion in investment today by employers to future health benefits for retirees and for all covered workers in the years after they retire.

Following LTV Corporation's filing for reorganization under Chapter 11 of the U.S. Bankruptcy Code in 1986, there was a sharp increase in congressional concern over the vulnerability of retiree health benefits. As part of the company's bankruptcy, LTV moved to terminate the health and life insurance benefits of more than 78,000 of its retirees. In moving to meet this crisis, the Congress was confronted with the larger and more difficult issue of whether the Nation's other companies would provide the health care coverage promised to their retirees or simply terminate their plans in the event of similar financial difficulties.

The LTV bankruptcy highlighted the problems surrounding the enormous unsecured promise of health benefits made to retirees across the Nation. In the case of LTV, a retaliatory strike by the steelworkers and Federal legislation forced the corporation to reinstate health benefits for 6 months. Congress also included provisions in the the Tax Reform Act of 1986 (P.L. 99-514) that permitted LTV to use certain tax benefits to fund the purchase of health and life insurance benefits. However, this incident spurred the Congress to enact legislation aimed at protecting other retirees who found themselves in similar straits. Included were: (1) provisions in the COBRA, Public Law 99-272, requiring the 18-month continuation of the provision of health benefits to retirees who otherwise would lose their health coverage upon retirement; (2) provisions in OBRA 1986, Public Law 99-509, requiring that companies entering Chapter 11 bankruptcy after July 1, 1986, continue health coverage for their retiring or retired employees for life, as well as coverage for their spouse and dependent children for 3 additional years in the event of their death; and (3) provisions in the continuing appropriations resolution for fiscal year 1986 (P.L. 99-591), requiring that the health and life benefits being paid by companies in Chapter 11 bankruptcy as of October 2, 1986, continue to be paid until May 15, 1987. Under provisions in Public Law 100-334, the last provisions were extended.

Reflecting congressional concern in this area, on August 7, 1986, the Senate Special Committee on Aging held a hearing on the difficulty of securing health benefits for retirees whose employers enter bankruptcy. Witnesses testified that while Congress could require vesting of health benefits at retirement, it would discourage employers from providing these benefits for current workers and even lead to a reduction of retiree health benefit coverage. In addition, while vesting would protect the health benefits of retirees of existing companies, it would not adequately protect the retirees of bankrupt companies. They would still lose their coverage and have only an unsecured claim for the value of the benefits. To survive bankruptcy, retiree health benefits would have to be funded and guaranteed in much the same way as are pension benefits, according to witnesses. However, they added that it was unlikely that even the most aggressive efforts would result in the adequate funding of retiree health benefits in the near future.

However, retirees have found some measure of protection for their employer-sponsored health benefits through the Federal courts, which increasingly have been forcing employers to honor what previously was regarded as an informal obligation. In *Eardman* v. *Bethlehem Steel Corporation* (607 F Supp. 196 (1984)), 16,000 nonunion retirees objected to changes in their medical plans which were instituted by Bethlehem Steel to contain costs. A U.S. district court, reviewing the terms of these plans, held that where the employer did not clearly retain the right to reduce or cancel retiree benefits, these benefits could not be reduced. After filing an appeal, Bethlehem agreed to provide a permanent health program for the retirees by combining features of the original and modified medical plan.

A Tennessee case, *Musto* v. *American General Corporation* (615 F. Supp. 1483 (1985)), went even further. While *Bethlehem Steel* had implied that employers were free to modify retiree benefits if those retirees had been informed of the possibility prior to leaving their job, *Musto* prohibits modification by the employer regardless of what employees or retirees have been told. *Musto* holds that employer health benefits vest upon retirement and are unchangeable thereafter regardless of the reservation clauses employers may have incorporated into plan documents.

While some hail the *Musto* decision as a far-reaching development in the protection of retirees' rights, others question whether its line of reasoning will do more harm than good. The Washington Business Group on Health (WBGH) has raised the concern that a prohibition against any change in retiree health plans would prevent employers from adopting plan modifications which would help to contain escalating health care costs and increase the quality of care provided. The WBGH has warned that depriving employers of the ability to modify plans in any way will have the effect of locking in plans which are outmoded and wasteful, and will impose the entire burden of cost containment on future retirees.

The lower court decision in *Musto* has been overshadowed by the 6th U.S. Circuit Court of Appeals decision in another case: *Hansen* v. *White Farm Equipment Co.*[34] In this case, the company cancelled retiree medical coverage when it filed for Chapter 11 reorganization. A U.S. district court reversed a bankruptcy court decision and held that the company had to continue coverage because retirees had a vested right to their health benefits at retirement and the clause the employers had included in the plan to reserve the right to terminate benefits had not been sufficiently clear.[35] On appeal, the appeals court reversed the district court, ruling that although retirees do have contractual rights in post-employment benefits, they are not automatically vested upon retirement, but subject to the terms of the contract.[36] The court held that only Congress, not the Federal courts, has the power to declare retiree medical benefits vested. The case was remanded to the bankruptcy court for a determination as to whether the information conveyed to the retirees clearly and expressly reserved the right of the company to terminate benefits.

The 6th Circuit decision in *White Farm* directly contradicts the *Musto* ruling by a lower court in the same circuit of vested benefits under Federal common law.

(B) FUNDING OF RETIREE BENEFIT PLANS

As a result of increasing pressure on employers to guarantee the health benefits they have promised to their retirees, employer concerns over the financial burden such benefits represent have mounted. A major factor at work has been the growing cost of health care. Rapidly rising health care costs have forced employers to recognize that more and more financial resources will be needed to provide health benefits to retirees in the future, particularly for companies with a high ratio of retirees to employees.

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[34] 23 Bankruptcy Reporter 85 (1982).

[35] 42 Bankruptcy Reporter 1005 (1984).

[36] *Hansen* v. *White Motor*, 788 F.2d 1186 (6th Cir. 1986).

Employers also are concerned that the Federal Government, in its efforts to contain costs under Medicare, will make changes in Medicare policy that shift more health care costs to employers. The unpredictability of future Medicare policy is of particular concern in light of various court decisions that have held employers liable for the delivery of promised health benefits.

A third factor in this area is the growing recognition among financial markets that retiree health plans represent current liabilities which must be counted against company earnings. Until 1985, companies were not required to include the financial liabilities associated with a retiree health plan in a financial statement. In fact, at that time few companies had any idea what their total liability was for providing the health care benefits promised to their future retirees.

However, in 1984, the Financial Accounting Standards Board (FASB), an independent, nongovernmental group which develops standards for financial reporting—for the first time required disclosure of plan liabilities, effective 1985. More specifically, employers were required to disclose in a footnote on their annual balance sheet information concerning how, or whether, their health benefits plans were prefunded. As part of this effort, in February 1989 the FASB released for comment a set of more comprehensive draft rules that would require that companies report both current and accrued expenses associated with retiree health benefits. FASB's final rule is expected in late 1990, although it will not be effective until at least December 15, 1991.

By focusing on the adequacy of employer prefunding of such benefits, FASB's proposed reporting requirements may significantly affect the financial standing of companies with large unfunded liabilities. Previously, investors paid scant attention to a company's current and future liabilities of their retiree health plans. Under the draft rules, however, companies would have to reveal these liabilities, possibly diminishing their attractiveness to potential investors as a result. Particularly for companies that are financially strained, this reporting requirement could further weaken their position in financial markets.

These factors have led some employers to consider prefunding their retiree health benefit plans. Relatively few employers currently prefund their plans and, to date, no consensus exists as to whether prefunding is desirable. Some employers feel that they are legally obligated to provide promised retirees health benefits and therefore should prefund their plans. Others, however, resist accepting these obligations and the notion of prefunding.

Prefunding will remain an unattractive option for employers until tax incentives are provided that offer favorable treatment for setting aside funds to finance future health benefits—similar to the favorable tax treatment that pension contributions currently receive. At present, however, the Federal Government appears unwilling to provide tax breaks to help offset the costs of funding these benefits without some minimum standards guaranteeing that retirees would be eligible for specified minimum benefits.

Indeed, as a result of provisions in the DEFRA 1984, one tax mechanism for prefunding of employer sponsored health benefits was significantly scaled back, effective January 1986. Previously, that law had allowed employers to establish a voluntary employee benefit association (VEBA) into which they could set aside unlimited funds to provide for retiree health benefits. To receive a tax deduction for these funds, the employer only had to certify that the funds would be used to pay for benefits. However, the Treasury Department persuaded the Congress that although the VEBA mechanism was not widely used, unlimited deductions were not appropriate for "contributions" which faced neither reporting and disclosure requirements, nor limitations on total funding.

In effect, the DEFRA 1984 provisions put the burden of justifying the need for a tax-favored funding mechanism for retiree health benefits on the employer. Also, the law placed a cap on the amount of funds that an employer could set aside for tax purposes, thus decreasing the value of VEBA's as a prefunding mechanism. At present, no more can be set aside than the total of a company's current expenditure for a particular benefit, plus 75 percent of that amount to account for future uncertainties. The 75 percent limit, according to benefit consultants, is far below the amounts needed to account for increases in the size of the retiree population and the rapidly escalating costs of health care.

4. Legislation

In the first session of the 100th Congress, legislation enacted to address problems in the area of securing retiree health benefits were largely crisis driven, resulting in short-term, stop-gap measures aimed at helping retirees of companies that filed for Chapter 11 bankruptcy. In response to LTV's attempt to terminate its retirees' health plan, two bills were signed into law in 1987 requiring the continuation of health benefits for the corporation's retirees. Legislation to protect retirees in a similar situation was subsequently enacted.

However, in 1988, the Congress developed a broader response to problems in this area. The enactment of the Retiree Bankruptcy Protection Act of 1988, signed into law on June 16, 1988, as Public Law 100-334, prevented employers from unilaterally canceling or reducing retiree health benefits when filing for bankruptcy under Chapter 11 and extended creditor status to retirees. Also, the law required the continuation of retiree health benefits pending agreement to modify benefits by the retiree's representative or to reduce or terminate benefits by a bankruptcy court.

In 1989, bills to encourage employers to prefund and vest retiree health benefits were introduced. Also, House and Senate proposals were included in OBRA of 1989 to allow employers on a tax-favored basis to use excess pension funds to finance the health benefits of current retirees. These provisions were dropped in conference, however a technical provision relating to contribution limitations on 401(h) accounts was adopted.

5. Prognosis

Congress is becoming increasingly concerned about the future of employer-financed retiree health benefits. To date, Federal legislation has sought to protect retirees in the event of a company's filing for bankruptcy under Chapter 11. In 1990 and beyond, however, congressional activity likely will stem from the impact of the expected ruling by the FASB to require employers to count unfunded retiree health benefit liabilities against company earnings. At present, the final ruling is expected to be issued in late 1990.

This anticipated change in accounting practices will place great pressure on employers to fund retiree health plans. Amid such pressures, employers may seek tax incentives from the Congress to help offset the costs of funding retiree health plans, possibly by easing up on the limitations that currently apply in this area. However, should employers also attempt to cut back retiree health care benefits to lessen the liability of such plans, the Congress also may look to ways to prevent abuses in this area.

C. HEALTH RESEARCH AND TRAINING

1. Background

Biomedical research is one of the most fundamental, yet often overlooked, ways to reduce health care costs and the need for long-term care. With the rapid expansion of the Nation's elderly population, the incidence of diseases, disorders, and conditions afflicting the aged also is expected to increase dramatically. For example, the incidence of Alzheimer's disease and related dementias is projected to double before the end of the century and quadruple by 2040, if biomedical researchers have not identified the cause and developed effective treatments.

Although scientific and medical research is making much progress in terms of decreasing or, in some cases, eradicating research on diseases specifically affecting the elderly population, it does not appear to be commensurate with the growth rate in this population. The Federal Government's investment in medical research is only about 1.2 percent of the total spending on health care in the United States. Fiscal year 1990 appropriations gives NIH $7.68 billion, an increase of 7.5 percent over 1989 appropriations compared with the 5.4 percent increase requested by the President.

Although the majority of this research is supported and funded through the National Institute on Aging (NIA) the NIH, the Alcohol, Drug Abuse, and Mental Health Administration, particularly the National Institute of Mental Health (NIMH), also is involved in considerable research activity relating to the elderly. Currently, the major research efforts at NIA are focused on understanding the basic mechanisms and characteristics of the aging process including the identification of genetic, molecular, and cellular markers that may eventually serve as measurements of the rates of aging. Researchers feel that such biomarkers can be used in systematic studies of various theories about aging and perhaps can serve as a valuable tool in the conduct of clinical trials and, ultimately, for treatment and prevention.

The Senate Special Committee on Aging and the House Select Committee on Aging played key roles in the congressional Briefing, "Reducing the Need for Long-Term Care: The Role of Research on Frailty and Long-Term Care," by the National Institute on Aging and the National Center for Nursing Research in October 1989. The briefing highlighted recent research on interventions to prevent frailty and the consequences this research has on long-term care issue. Current research focuses primarily on the institutional care setting, which is not adequate to assess informal caregiving situations. As the significance of home and community health care increases to meet long-term health care needs, research in the informal caregiving situation should increase as well.

Currently, it is estimated that 36 percent of all health costs in the United States are spent on the 12 percent of the population which is over age 65. With the projected rapid expansion of the aging population, it is expected that by the year 2000, one-half of the health cost dollar will be spent on older Americans.

In many parts of the United States, the health care system is unable to deal with the current needs of elderly patients suffering from dementia and other diseases. To meet those needs, the Federal Government is expanding the scope of its research activity regarding services to meet the more immediate needs of Alzheimer's disease patients and their families. Specialized professional training for health care providers working with geriatric patients is another emerging, significant, and severely undermet need that Congress is beginning to address.

(A) THE NATIONAL INSTITUTES OF HEALTH

NIH, which celebrated its centennial in 1987, seeks to improve the health of Americans by increasing understanding of the processes underlying disease, disability, and health and by helping to prevent, detect, diagnose, and treat disease. It supports behavioral and biomedical research through grants to facilities, conducts research in its own laboratories and clinics, and trains young scientific researchers.

With the rapid aging of the U.S. population, one of the most important research goals is to distinguish between aging and disease in older people. Findings from NIH's extensive research into both of these areas increasingly challenges health providers to seek causes, treatment, and prevention of the many ailments of the elderly, rather than to dismiss them as being the effects of the natural course of aging. A more complete understanding of normal aging as well as disorders and diseases also facilitates progress in health promotion, medical education, and health policy and planning.

(1) History of NIH

NIH traces its beginning as a health research organization of the Federal Government to the establishment of the Laboratory of Hygiene for research on cholera and other infectious diseases in 1887 as part of the Marine Hospital Service at Staten Island, NY. The Marine Hospital Service was a forerunner of the present Public Health Service. In 1930, Congress passed the Ransdell Act, which renamed the Laboratory of Hygiene and created the National Institute of Health. The Ransdell Act also authorized a system of fellowships and the construction of two buildings "for study, investigation, and research into the fundamental problems of the diseases of man."

With the passage of the Social Security Act in 1935, up to $2 million annually was authorized for the "investigation of disease and problems of sanitation," but appropriations ranged from $375,000 in fiscal year 1936 to $707,000 in fiscal year 1940. Congress authorized the creation of the National Cancer Institute in 1937 as a division of the Public Health Service. The Public Health Service was revised and consolidated in 1944, giving NIH its postwar legislative basis establishing permanent, general authority to conduct research.

The National Heart Act, passed in 1948, established the National Heart Institute and changed the name of the National Institute of Health to the National Institutes of Health. Since then, many more institutes have been established and the NIH budget has grown from $8 million to almost $7.1 billion.

(2) Health Research Extension Acts of 1983 and 1985

These bills, to amend the Public Health Service Act relating to the National Institutes of Health, became a point of confrontation between the White House and the Congress. The Health Research Extension Act of 1983 was passed by Congress and then pocket vetoed by the President in 1984 after Congress adjourned. It was reintroduced in 1985, again passed by Congress, and, once again, was vetoed by the President. This time, however, the veto was overridden by a 380-32 in the House and 89-7 in the Senate.

The administration's objections focused on the creation of a new nursing research center, the imposition of a uniform set of authorities on all research institutes, and additional administrative and program requirements. However, in 1985, the President, in his veto message, acknowledged the need to establish a National Institute of Arthritis, a point on which he had vetoed the Health Research Extension Act in 1984.

The new legislation also reauthorized the National Cancer Institute and the National Heart, Lung, and Blood Institute, established a Biomedical Ethics Advisory Board, increased emphasis on the humane care of laboratory animals, and provided explicit statutory authority for each of the institutes while retaining the authority of the Secretary of the DHHS to support research and reorganize the institutes.

(3) The Institutes

Much of the research into particular diseases, disorders, and conditions at NIH is collaborative, with different institutes investigating pathological aspects related to their specialized approach. At leaste 10 of the NIH research institutes investigate areas of particular importance to the elderly. They are:

National Institute on Aging
National Cancer Institute
National Heart, Lung, and Blood Institute

National Institute of Dental Research
National Institute of Diabetes and Digestive and Kidney Diseases
National Institute of Neurological and Communicative Disorders and Stroke
National Institute of Allergy and Infectious Diseases
National Eye Institute
National Institute of Arthritis, Musculoskeletal, and Skin Diseases
National Center for Nursing Research

(a) National Institute on Aging

The National Institute on Aging (NIA) was established in 1974 in recognition of the many gaps in scientific knowledge of aging processes. NIA conducts and supports a multidisciplinary program of geriatric research, including biological, social behavioral, and epidemiological aspects of aging phenomena. Through research and health information dissemination activities, its goal is to prevent, alleviate, or eliminate the physical, psychological, and social problems faced by many older people.

NIA areas of biomedical and clinical research include Alzheimer's disease, molecular genetics to understand the basic mechanisms of aging, the effects of infections and toxins on the aging nervous system, the ability of transplanted brain cells to enhance memory and reverse learning deficits in animals, brain metabolism, function, and biochemical diagnostic tests as related to dementia and aging, burden-of-care, and osteoporosis, hip fractures and falls.

(b) National Cancer Institute

The National Cancer Institute (NCI) conducts and sponsors basic and clinical research relating to the cause, prevention, detection, and treatment of cancer. Of all new cancer cases reported, more than half are elderly patients, and more than 60 percent of all persons who die of cancer each year are older Americans.

Although the rate of cancer survival has increased to 50 percent from the 30 percent of the 1950's due to advancements in surgery, radiation, and chemotherapy treatment, the rate of overall cancer incidence and mortality has been increasing, particularly in those 55 and older.

In addition to basic and clinical, diagnostic, and treatment research, NCI supports a prevention and control program emphasizing such programs as assistance to stop smoking programs.

(c) National Heart, Lung, and Blood Institute

The National Heart, Lung, and Blood Institute (NHL&BI) focuses on diseases of the heart, blood vessels, blood, and lungs and on the management of blood resources. Three of the most prevalent chronic conditions affecting the elderly—hypertension, heart conditions, and arteriosclerosis—are studied by NHL&BI. In 1987, more than 1 million deaths were reported from all of the diseases under the purview of NHL&BI with associated economic costs of nearly $165 billion including $75.5 billion in direct health care expenditures. Nearly 40 percent of all elderly suffer from hypertension, 25 percent from a chronic heart condition, and 8 percent from arteriosclerosis.

Current research efforts include cholesterol-lowering drugs, DNA technology and genetic engineering techniques for treatment of emphysema, basic molecular biology research in cardiovascular, pulmonary, and related hematologic research and regression of arteriosclerosis.

NHL&BI also conducts an extensive professional and public education program on health promotion and disease prevention, particularly as related to blood pressure, blood cholesterol, and coronary heart disease. This has played a significant role in the 58 percent decline in stroke death and 40 percent decline in heart disease over the past 20 years.

(d) National Institute of Dental Research

The National Institute of Dental Research (NIDR) supports and conducts research and research training on oral health and disease. Major goals of NIDR include prevention of tooth loss and preservation of the oral tissues from the main dental diseases, caries, and periodontal. Other research areas include birth defects affecting the face, teeth, and bones; oral cancer; infectious diseases; chronic pain; epidemiology; and basic studies of oral tissue development, repair, and regeneration.

In a national study in 1986–87, NIDR found that 42 percent of men and women age 65 and older examined (in the survey) had lost all of their teeth, compared to only 4 percent of adults between 18 and 65. Older Americans also face extensive periodontal disease, a major cause of tooth loss. Faced with these findings, the Institute has expanded oral health research with the elderly and is collaborating with the NIA and the VA in an oral health research and promotion and disease prevention project.

(e) National Institute of Diabetes and Digestive and Kidney Disease

The National Institute of Diabetes and Digestive and Kidney Disease (NIDDK) conducts and supports research and research training in diabetes, endocrinology, and metabolic diseases; digestive diseases and nutrition; and kidney, urologic, and blood diseases.

Diabetes, one of the Nation's most serious health problems and the largest single cause of renal disease, affects 11 million Americans at an annual cost to society of $20.4 billion. Nearly 10 percent of the elderly are believed to be diabetic.

(f) National Institute of Neurological and Communicative Disorders and Stroke

The National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) supports and conducts research and research training on the cause, prevention, diagnosis, and treatment of hundreds of neurological and communicative disorders. This involves basic research to understand the mechanisms of the brain and nervous system and clinical research.

Most of the disorders studied by NINCDS result in long-term disabilities and involve the nervous system (including the brain, spinal cord, and peripheral nerves), muscles, hearing and hearing communication. Of particular concern to the elderly is research on stroke, Huntington's disease, Parkinson's disease, amyotrophic lateral sclerosis, and the dementias, including Alzheimer's disease. NINCDS research is also focusing on neuroimaging technology and molecular genetics to determine the etiology of Alzheimer's disease.

Stroke, the Nation's third-leading cause of death and most widespread neurological problem, primarily affects the elderly. New drugs to improve the outlook for stroke victims and surgical techniques to decrease the risk of stroke currently are being studied.

(g) National Institute of Allergy and Infectious Diseases

The National Institute of Allergy and Infectious Diseases (NIAID) with basic and clinical applications, focuses on two main areas: infectious diseases and diseases related to immune system disorders.

Influenza can be a serious threat to older adults. NIAID is supporting and conducting basic research and clinical trials to develop treatments and improved vaccines for high-risk individuals from influenza. Since older persons also are particularly vulnerable to hospital-associated infections, NIAID research is leading to a vaccine for protection against one of the most common, difficult to control, and often fatal infections, P. aeruginosa.

(h) National Eye Institute

The National Eye Institute (NEI) conducts and supports research and research training about the prevention, diagnosis, treatment, and pathology of diseases and disorders of the eye and visual system. Glaucoma, cataracts, and aging-related maculopathy, which are of particular concern to the elderly, are being studied by NEI. Some of this research is intended to serve as a basis for future outreach and educational programs aimed at those with the highest risk of developing glaucoma.

(i) National Institute of Arthritis, Musculoskeletal, and Skin Diseases

The Institute of Arthritis, Musculoskeletal, and Skin Diseases (NIAMS) investigates the cause and treatment of a broad range of diseases including osteoporosis and the many forms of arthritis. In 1988, the Institute announced its support for the formation of nine specialized centers of research for in-depth research on rheumatoid arthritis, osteoarthritis, and osteoporosis. The research centers, funded by Congress in 1987, will receive NIAMS funding for 5 years.

NIAMS hopes to make contributions to the national research effort for these diseases, which it says are among the Nation's most critical health problems. Affecting over 40 million Americans, these diseases are among the more debilitating of the more than 100 types of arthritis and related disorders. They primarily affect individuals over 50 years of age. Older adults are particularly affected. Almost 50 percent of all persons over the age of 65 suffer from some form of chronic arthritis. An estimated 24 million Americans, most of them elderly, have osteoporosis.

Among topics of research on the cause and treatment of rheumatoid arthritis, a chronic inflammatory disease of unknown cause, are: the study of immune cells present in the synovial fluid around arthritic joints and the genetic basis for production of rheumatoid factor (an abnormal antibody found in the blood of patients with rheumatoid arthritis).

Research on osteoarthritis, a degenerative joint disease, includes a focus on changes in the network of surrounding cartilage cells in the joint.

For osteoporosis, which causes loss of bone mass, researchers are studying the effects of estrogen replacement therapy and the effects of disuse, age, and hormones on osteons, the building blocks of bones.

(j) National Center for Nursing Research

The National Center for Nursing Research (NCNR) conducts, supports, and disseminates information about basic and clinical nursing research through a program of research, training, and other programs. Research related to the elderly includes depression among patients in nursing homes to identify better approaches to nursing care, physiological and behavioral approaches to combat incontinence, initiatives in areas related to Alzheimer's disease, including burden-of-care, osteoporosis, pain research, and the ethics of therapeutic decisionmaking.

(B) NATIONAL INSTITUTE OF MENTAL HEALTH

As one of three institutes of the Alcohol, Drug Abuse, and Mental Health Administration, the National Institute of Mental Health (NIMH) is involved in extensive research relating to Alzheimer's and related dementia and the mental disorders of the elderly. NIMH is focusing on identifying the nature and extent of structural change in the brains of Alzheimer's patients to develop a comprehensive approach to the neurochemical aspects of the disease. NIMH research has discovered a protein specific to Alzheimer's which shows promise of being a positive diagnostic marker for the disease. Research into amnesia is increasing knowledge about Alzheimer's and other dementia, and on the extent of structural change in the brain as well as the neurochemical aspects of the disease.

(C) GERIATRIC TRAINING

Essential to effective, high quality, long-term, and other health care for the elderly is an adequate supply of well-trained health care providers, including physicians, physicians' assistants, nurses, dentists, social workers, and gerontological aides. For decades, the Federal Government has supported the education and training of health care professionals by providing financial assistance through a variety of Federal and State agencies. This support was relatively unrestricted and unfocused, aimed at increasing the numbers of all types of health care professionals.

By the mid-1970's, this generalized effort had proven successful and Congress then focused on particular problem areas in the supply of health care professionals, such as geographic and specialty shortages. For example, special trainee and residency programs were established for preventive, family and general internal medicine, physician assistants, and minority health education.

Congress now is beginning to focus more attention on training and education for geriatric care although funding still is limited. The Health Professions Special Education Initiatives Program has been established by Congress to carry out high-priority initiatives in the national interest. Funding has been awarded to schools and other institutions which train health professionals for special educational training programs in geriatrics, health economics, health promotion, and disease prevention, and computer-simulated medical procedures.

Under this initiative, geriatric education centers (GEC's) provide short-term multidisciplinary faculty training, curriculum, educational resource development, and other assistance in affiliation with other educational institutions, hospitals, nursing homes, VA hospitals, and community-based centers for the elderly. Many GEC's also serve as geriatric evaluation units which provide clinical training. Congress also has initiated a new program under the Public Health Service Act for traineeships and fellowships to initiate in-depth training of faculty in geriatrics for training of future health care providers in geriatrics.

2. Issues and Legislation

(A) ALZHEIMER'S DISEASE

For the last several years, Congress has become increasingly concerned about the serious and growing problems of Alzheimer's disease and related dementias. This progressive and irreversible degenerative brain disease is the fourth-leading killer in the United States. A recent epidemiological study by Denis Evans, et al., for the first time gives a clear picture of the number of Alzheimer's patients in the elderly population. Previous figures often estimated 2.5 to 3 million Americans are afflicted with Alzheimer's disease. The Evans study, supported by the National Institute on Aging, reports the number is now approximately 4 million Americans over the age of 65; this number represents 14 percent of the elderly population.

This study also found that the prevalence of Alzheimer's rose more rapidly with age than previously suspected. Overall about 10.3 percent of persons over 65 living at home had Alzheimer's disease. Of those 65–74 years of age, 3 percent had Alzheimer's disease compared to 18.7 percent of those aged 75–84 and a striking 47.2 percent of those over the age of 85. Since those 85 and older is the most rapidly growing sector of the population, the number of Alzheimer's patients is expected to dramatically increase to about 14 million persons in 2040 if nothing is done to prevent or cure the disease. As the prevalence of dementia escalates in the coming decades, so too will the costs—financial, physiological, psychological, emotional, and personal.

Congressional consideration of Alzheimer's disease has focused on increased funding for research on the causes, diagnosis, and treatment of the disease. At present there are no established effective means of prevention or treatment, so concern is centering on the cost and ways of providing care for its victims. The burdens and costs of care are roughly $80 million annually. With growing numbers of older persons susceptible to the disease, associated costs could reach almost catastrophic proportions early in the next century.

Most of the federally funded research into Alzheimer's disease is being carried out by the NIA, NINCDS, the NIAID, the NEI, the NCNR, the NIMH, the HCFA and the AoA. The AoA has supported research and demonstration programs to develop and strengthen family and community-based care for Alzheimer's disease victims.

A great deal of progress has been made recently in the understanding of the cellular and chemical basis of the disease. Recent studies on the molecular genetics of Alzheimer's disease indicate a linkage between chromosome 21 and the familial or early onset form of Alzheimer's disease. Other important findings point to the potential for biomedical diagnostic tests based on the detection of specific biological markers. Other avenues being explored include enzyme deficiencies, abnormal neurons, a slow virus, an abnormal protein, a genetic defect, a defect in calcium regulation inside the nerve cell, and an accumulation of aluminum in the brain.

Research into treatment of the disease has focused on testing drugs for treating Alzheimer's major symptoms—loss of memory and intellect. No drugs yet have been tested that might stop the underlying progressive process of the disease. Many of the drugs under investigation increase the amount of acetylcholine in the brain. Currently NIA is sponsoring clinical trials on the safety and efficacy of tetrahydroaminoacridine (THA), an experimental drug which may help control memory loss. The study, begun in 1987, was temporarily suspended when 20 of the first 50 patients enrolled in the drug trial developed toxic liver problems. The doses of THA were subsequently reduced and the experiment continued with plans to enroll up to 300 patients. Initial results will be available in the spring of 1990.

The Alzheimer's Disease Research Centers, established by Congress in 1984, are an important component of the national effort to find a cause and cure for this disease. Since funding began in 1984 through grants from the NIA, the centers have established special units for clinical and basic research as well as behavioral studies of Alzheimer's and related disorders. NIA currently funds 15 centers. Based primarily at universities and hospitals, the centers also train scientists and health care providers, and fund new research projects. Guidelines for the centers were developed by NIA along with the NIMH, the NINCDS, and the NIAIDS.

In 1986, Congress passed the Alzheimer's Disease and Related Dementias Services Research Act of 1986 as part of the Omnibus Health bill (P.L. 99-487). Many consider this to be a landmark piece of legislation in that it directs researchers to develop the services needed by individuals with Alzheimer's disease and related dementias and their families. It also established within the DHHS the Council on Alzheimer's Disease to coordinate research on Alzheimer's disease and related dementias and the care of individuals with dementia.

In addition, the Budget Reconciliation Act for 1986 (P.L. 99-509), authorized up to 10 Medicare demonstration projects, with an appropriation of $40 million over 3 years, through which a limited number of Alzheimer's patients would receive benefits not previously covered by medicare. This demonstration began on May 15,

1989. Eight cities are participating: Rochester, NY; Miami, FL; Cincinnati, OH; Memphis, TN; Portland, OR; St. Paul, MN; Urbana, IL; and Parkersburg, WV. Services being provided and paid for under Part B of Medicare are case management; adult day care; homemaker and personal care; mental health; and education and counseling for caregivers. Two different models of case management are being tested in the demonstration, with case managers at certain sites being responsible for 100 clients, and case managers at other sites having 30 clients. Demonstration sites will be paid by Medicare a certain amount per month for each client enrolled. Beneficiaries would be responsible for 20 percent of this amount, as they are for Part B services. The demonstration will run for 3 years, and after completion, an evaluation of the project will be published by the HCFA.

In March 1989, the Advisory Panel on Alzheimer's Disease, established under Public Law 99-660, released its first annual report. This is the first in an ongoing series of annual reports which contain public policy and science policy recommendations for administrative and legislative actions in the areas of health services, biomedical research, and the financing of health care to benefit those with Alzheimer's disease. The 1988-89 report recommended a $300 million per year increase in the biomedical research budget. Specifically, the panel recommended that the annual funding for Alzheimer's disease research and evaluation be increased by $25 million immediately, and by $50 million within 3 to 5 years. The advisory panel also focused on the problems with the current long-term care programs, which they feel are fragmented and inadequate. They recommended that the Congress create a Federal long-term care insurance plan to replace Medicaid as the primary source of funding the Nation's long-term care needs. Future reports will include personnel and training needs and legal issues.

(B) OSTEOPOROSIS

Osteoporosis is a major debilitating health problem for an estimated 24 million Americans—half of all women over age 45 and 90 percent of women over age 75. Although the majority of osteoporosis victims are women, men constitute approximately 20 percent of all people with the disease. Osteoporosis, characterized by chronic loss of bone mass, leads to an increased risk of hip, neck, and wrist fractures, immobility, disability, and sometimes, death. Medical costs, now estimated at $10 billion annually, will increase significantly as the population ages and incidence increases.

Every year, osteoporosis is responsible for 1.3 to 1.5 million bone fractures in those over age 45, or about 70 percent of all bone fractures in that age group. Most of the approximately 250,000 hip fractures suffered by individuals over 45 in 1988 were attributable to osteoporosis. This specific type of fracture often has catastrophic outcomes. According to a recent OTA report, some 12 to 20 percent of all people who have hip fractures die as a result of the fracture and related conditions. Approximately another 15 to 30 percent are forced to enter an institutional care setting.

Currently, there is no proven method for restoring bone mass in a person once osteoporosis is detected. Therefore, prevention is the primary focus of biomedical research for this particular condition. Medical experts agree that osteoporosis is highly preventable through early screening, balanced diet, regular exercise, limited intake of alcohol, and not smoking tobacco. The National Osteoporosis Foundation stresses, however, that if the rate of osteoporosis is to be slowed, Federal appropriations for research must be significantly increased.

Potential research topics include studies of basic bone biology and bone remodeling related to osteoporosis; improved therapies to increase bone mass; better screening methods to measure bone density; estrogen therapy; bone homeostasis and calcium intake, absorption, and excretion; and the effect of exercise on bone.

The latest scientific consensus on osteoporosis recognizes estrogen and calcium deficiencies as the major causes of postmenopausal osteoporosis while certain drugs could be precipatory agents. It has recently been discovered that bone cells contain receptors for estrogen and that estrogen treatment in postmenopausal women can protect against hip fractures in later years, although there is concern about the possible risks involved with this treatment. A recent article published findings from a Swedish study that documented a higher incidence of breast cancer in women who have received estrogen replacement therapy.[1]

Scientists also agree that calcium cannot substitute for estrogen in preventing the accelerated bone loss that occurs in the 8-10 years following menopause.

A number of experimental therapies are under consideration for the prevention and perhaps treatment of osteoporosis. Diphosphonates, such as etidronate, coat bone crystal which prevents the process of bone resorption. This treatment would not only benefit prevention studies, but it could prove successful in patients with established osteoporosis. Clinical trials are currently underway for this promising treatment, which is comparatively inexpensive and safe.

(C) ARTHRITIS

Arthritis, an inflammation of the joints, is used to describe the more than 100 rheumatic diseases. Many of these disorders affect not only the joints, but other connective tissues of the body as well. Approximately one in seven persons have some form of rheumatic disease, making it the Nation's leading crippler.

The NIAMS conducts the primary Federal biomedical research for arthritis and related disorders. Support research on these disorders is also carried out by the NHLBI, the National Institute of General Medical Sciences, the NCNR, and the Office of the Director, NIH. Although no cure exists for the many forms of arthritis, progress has been made through clinical and basic investigations. The two most common forms of arthritis are osteoarthritis and rheumatoid arthritis.

Osteoarthritis (OA), a degenerative joint disease, affects more than 16 million Americans. OA causes cartilage to fray, and in extreme cases, to disappear entirely, leaving a bone-to-bone joint. Disability results most often from disease in the weight-bearing joints, such as the knees, hips, and spine. Although age is the primary risk factor for OA, age has not been proven to be the cause of this cripping disease. NIA is focusing on studies that seek to distinguish between benign age changes and those changes that result directly from the disease. This distinction will better allow researchers to determine the cause and possible cures for OA.

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[1] L. Bergkvist, H. Adami, I. Persson, et al., "The Risk of Breast Cancer After Estrogen-Progestin Replacement," New England Journal of Medicine, 321 (5): 293-397, Aug. 3, 1989.

Rheumatoid arthritis (RA) is a chronic inflammatory disease affecting more than 2.1 million Americans, two-thirds of whom are women. RA causes joints to become swollen and painful, and eventually deformed. There are no known cures for RA, but research has discovered a number of therapies to help alleviate the painful symptoms. Guanethidine, a regional nerve blocker, has been found to decrease pain and increase finger-pinch-strength in patients with active RA. Another drug, cyclosporin A, lessens the pain and swelling of the joints. Its toxicity for the kidney and elsewhere, however, limits its therapeutic value.

(D) GERIATRIC TRAINING AND EDUCATION

Although the Federal Government is beginning to recognize the current and future need for health care professionals trained in geriatric care, it has yet to appropriate significant funding for geriatric education and training.

This lack of funding poses a dilemma for an aging society in which demands for geriatric and related serviced by those 65 and older are increasing at an unprecedented rate. In a 1987 report, Personnel for Health Needs for the Elderly Through Year 2020, the NIA said that projections of potential use of services by the elderly population by 2020 show a expansion of more than twice the 1980 volume.

NIA predicted that older adults will compose up to two-thirds of the practices of most physicians and other health caregivers. Primary care practitioners in family and internal medicine are expected to continue to provide most of the medical care for the aged. NIA also predicted that requirements for personnel specifically prepared to serve older people will greatly exceed the current supply.

If current medical school enrollments remain stable, the number of practicing physicians in the year 2020 will be approximately 850,000. NIA estimates that the annual rate of increase of physician supply between 1985 and 2020 will be slightly less than the comparable growth rate of the elderly population during that period. An estimated 14,000 to 29,000 geriatricians may be needed by 2020, it said.

Yet most health professions education programs give relatively little emphasis to issues relating to geriatrics and aging, NIA said, and shortages of faculty members and other leaders with adequate preparation in aging and geriatrics pose a serious constraint on education and training needs.

The most serious shortage is in the number of faculty members and other leaders that have specialized backgrounds in aging and geriatrics who can develop and teach undergraduate, graduate, inservice, and continuing geriatric education programs. The report stated that only 5 to 25 percent of the teaching faculty and researchers estimated to be needed to develop sufficient education training programs are currently available. Therefore, the report strongly recommended that the first priority must be to greatly expand the number of faculty members and other leaders to plan, develop, guide, and provide the training, consultation, and research needed for geriatric education and training.

The report also recommended that education and service programs should give special attention to high priority services such as home, community-based and nursing home services, rehabilitative care, and health promotion and disease prevention activities. Special attention was also recommended for high-risk groups such as Alzheimer's disease patients and the very frail elderly.

Among the most critical health care issues for the elderly in the future are the personnel and training needs for caregivers who work with residents in nursing homes, NIA said. Projections through the year 2000 of the need for full-time registered nurses in nursing homes range from 260,000 (about three times the staffing levels in 1983–84) to 838,000. The estimates of demand for other licensed nursing personnel ranges from 300,000 to 339,000 and for nursing aides, the prediction is that 1 million will be needed by the year 2000.

Inadequate training is one of the many problematic issues facing workers in nursing homes and private homes, according to the Older Women's League. These 1.5 million workers, mostly women, and mostly middle-aged, receive little or no training, OWL said in its 1988 report, "Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly."

OWL reported that chronic care workers are in extremely short supply in some areas, most notably in the northeastern States. Among the many reasons reported for high turnover rates among these workers are low wages and few benefits; inadequate training, orientation, and supervision; and no pay for classroom training.

The NIA report found that the most effective way of providing multidisciplinary geriatric training was through collaborative arrangements between academic institutions and providers. Financing has come from many sources, including State, local and private funds, and Federal programs. The report recommended that financing of geriatric education and training programs continue to come from multiple sources and be targeted on strengthening proven approaches. It also recommended that Medicare and other health care financing programs emphasize alternative training approaches such as in-service training and continuing education in geriatrics.

Finally, the study found many gaps in the information that is available about the health services the elderly receive and the status of related training and education programs. It was recommended that ongoing studies be continued to develop additional data for future analyses and more specific recommendations.

(E) LEGISLATION

Although a number of bills involving Alzheimer's disease were introduced in the 101st Congress, the only legislative item approved in the first session was an appropriation bill.

Reauthorization of a number of programs relating to the NIH was included in S. 2889, the "Health Omnibus Programs Extension of 1988" which was passed in the closing days of the 100th Congress and signed into law on November 4, 1989 (P.L. 100-607). A new Institute is created under this law, the "National Institute on Deafness and Other Communication Disorders," which is concerned with disorders of hearing and other communications processes, including diseases affecting hearing, balance, voice, speech, language, taste, and smell. It is estimated that 22 million Americans have partial or total loss of hearing and another 2.3 million persons suffer from communication disorders. About half of these persons are over 65 years of age.

The two largest institutes, the NCI and the NHL&BI, were reauthorized for 3 years. The law also established a National Center for Biotechnology Information for the design and development of automated computer systems to be used for research concerning human molecular biology, biochemistry, and genetics.

(1) NIH Appropriations

For a second year in a row, the President's fiscal year 1990 budget proposal reverses previous administration positions on the Federal commitment to biomedical research by funding NIH at $7.53 billion—$380 million above appropriations for fiscal year 1989.

Congress' continued support for biomedical research is reflected in the conference report for H.R. 3566 (P.L. 101-166) for Labor, Health and Human Services, and Education appropriations, which provides funding for NIH at a level of almost $7.58 billion, an increase of about $431 million over 1989 and the largest budget in the history of the NIH. Of this amount, $744 million is designated for AIDS research.

(2) NIMH's Appropriations

The NIMH's appropriation for mental health research for fiscal year 1990 if $419 million (before sequestration), up from $354.5 million in fiscal year 1989. The conference report said that this increase would fund important expansions into the neurosciences as recommended by the "Decade of the Brain" report, and into schizophrenia and Alzheimer's disease. The House appropriations committee indicated in its report that NIMH should increase its research efforts in the important areas of aging disorders because of the fast-growing incidence of dementia.

(3) Geriatric Training

The Health Omnibus Extension Act (P.L. 100-607) also included the Health Professions Reauthorization Act of 1988 which reauthorized the program that provides grants and contracts to geriatric education centers (GEC's) and for geriatric training projects to train physicians and dentists who plan to teach geriatric medicine or geriatric dentistry. $7 million was authorized for each program for fiscal year 1989, $10 million for fiscal year 1990, and $13 million in fiscal year 1991. Under the GEC provisions, grants and contracts can be provided to health professions schools, including schools of allied health, related to the treatment of health problems of the elderly. Other provisions included new affiliations with nursing homes, ambulatory care centers, and senior centers to provide students with clinical training in geriatric medicine.

The appropriations bill for fiscal year 1990 also provided $14.3 million (before sequestration) for geriatric training programs, an increase of only $0.8 million over fiscal year 1989. Of this, funding was provided to establish up to two GEC's for geriatric research and training.

4. PROGNOSIS

Within the past 50 years, there has been an outstanding improvement in the health and well-being of the American people. Formerly deadly diseases have been controlled or eradicted and the survival rates for victims of heart disease, stroke, and cancer have improved dramatically. Many directly attribute this success to the efforts of our Nation's medical and research community which has been possible because of the Federal Government's longstanding commitment to the support of biomedical research.

Now, as Congress grapples with the persistent Federal budget deficit, the Nation is also confronted with the current and impending costs of caring for rapidly increasing numbers of persons afflicted with two deadly and devastating diseases—Alzheimer's and AIDS. Congress has responded with increased resources but consistent and sufficient Federal support is essential in order to follow promising research to unravel the cause, develop treatments and possible prevention of these and many other costly diseases, such as cancer and diabetes, which have so far been incurable.

Also, with the projected phenomenal increases in our country's over-age 85 population, study after study has called for tremendous increases in the number of health professionals trained in geriatric care. While Congress has recognized and initiated programs to meet this need, the Federal commitment for funding has been very limited and may continue to be in the face of budget constraints.

The administration is expected to sustain its reversal of earlier positions of cutting budgets and to support increased funding for biomedical and clinical research. As in the past, Congress is anticipated to continue its commitment to health research—with close scrutiny of progress and promise; and sustained and increased Federal financial support.

Chapter 8

LONG-TERM CARE

OVERVIEW

When a chronic illness strikes, most older Americans find that the long-term care services they need are not covered by Medicare, other public programs, or private insurance. Many elderly persons and their families pay the full costs out-of-pocket, making long-term care the single greatest threat to the financial security of older Americans and their families.

There have been no significant public or private improvements in long-term care financing and delivery within the last several years. The reluctance to implement new long-term care initiatives can be attributed to three major factors. First, the 6 million older Americans who need long-term care are a relatively new phenomenon. More Americans are living longer than ever before, and the incidence of chronic illness—and hence the need for long-term care—increases dramatically with advancing age. Second, the enormous costs of improving access to long-term care services for the elderly tend to deter interest in comprehensive legislative reform, particularly in light of growing budget deficits and competing interests. Third, no consensus exists on the best way to finance long-term care.

As the need for increasing access to and affordability of long-term care continues to grow more pressing, there is evidence of heightened congressional interest. However, this interest has yet to be translated into congressional action, and the first session of the 101st Congress ended with little or no legislative action on the issue of comprehensive coverage of long-term care. Nonetheless, long-term care remains an issue of top priority to many Members of Congress, and several bills were introduced in 1989 to address this issue.

Although the Medicare Catastrophic Coverage Act of 1988 (MCCA) provided largely acute care services, the controversy and eventual repeal of nearly the entire bill in November 1989 have had a direct impact on long-term care. A great deal of the controversy surrounding MCCA centered on the fact that it did not provide comprehensive coverage for long-term care, which many believed were the benefits that beneficiaries most needed and wanted. Therefore, there was broad-based agreement that the Bipartisan Commission on Comprehensive Health Care, which was formed under MCCA to study the interrelated issues of long-term care and the under- and uninsured should not be repealed with the rest of MCCA. Efforts to salvage the Commission and the Medicaid-related provisions were successful. Renamed the Pepper Commission, after the late Senator Claude Pepper who chaired the Commission, its March 1, 1990, report on policy recommendations to address these issues is eagerly anticipated.

Many see the solution to the long-term care problem in the form of a public-private partnership. However, private initiative alone are unlikely to solve more than a small portion of the problem. The experience of private insurers to date has been disappointing. Long-term care insurance policies have not been popular with the American public, especially among those young enough to purchase insurance when it is more affordable. Employers, too, have shown a reluctance to offer a new long-term care benefit, though there are now available several group plans offered by insurance companies.

A. BACKGROUND

1. Types of Long-Term Care

The phrase "long-term care" encompasses a wide array of services offered in a variety of settings ranging from institutional settings (such as nursing homes) to noninstitutional settings such as adult day care centers and a person's own home. Community-based long-term care typically encourages a variety of noninstitutional health and social services such as home health care, homemaker, chore and personal services, occupational, physical and speech therapy, adult day care, respite care, friendly visiting, and nutritional and health education. The great majority of long-term care services are provided by family members. According to the 1982 National Long-Term Care Survey, about 75 percent of disabled older people not in nursing homes received assistance from relatives and friends.

Long-term care services provide for the needs of those individuals who are not able to completely care for themselves as a result of chronic illness or physical or mental conditions which result in both functional impairment and physical dependence on others for an extended period of time. Those groups needing long-term care include the elderly and nonelderly disabled, the developmentally disabled (primarily the mentally retarded), and the mentally ill. Older people, because of their high risk of chronic illness that results in disability and functional impairment, are the primary recipients of long-term care in this country.

The range of chronic illnesses and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute illnesses, which occur suddenly and usually are resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically except to maintain the status quo of the patient.

Although chronic conditions can occur at any age, their incidence, particularly as they result in disability, increases with age. Moveover, its prevalence rises with advancing age. According to the 1984 Long-Term Care Survey, about 16.4 percent of persons aged 65–74 living in the community have some limitation for which they need assistance, as compared to 47 percent of persons aged 85 years or older. However, the presence of a chronic illness or condition alone does not necessarily result in a need for long-term care, and most older persons are able to live independently in spite of these conditions.

It is when these chronic conditions manifest themselves in functional or activity limitations called limitations in "activities of daily living" (ADLs) that assistance may be required. Examples of ADLs include bathing, dressing, eating, getting in and out of bed, etc. A second set of measures, called limitations in instrumental activities of daily living (IADLs), reflect a lower level of disability such as difficulties with shopping, cooking, cleaning, and taking medicine.

2. NUMBERS OF PEOPLE RECEIVING LONG-TERM CARE

(A) NURSING HOME CARE

Of the 28.6 million people age 65 and older in the United States in 1985, less than 25 percent (6.3 million) were disabled. Of this group, about 2.6 million were severely disabled, that is, needing assistance with three or more ADL's. However, only about 21 percent (1.3 million) of the disabled elderly were residing in nursing homes. Those with severe disabilities were more likely to be in nursing homes, although more than half of the severely disabled were residing in the community.[1]

Because the elderly population, particularly those age 85 and older, is growing, nursing homes will be increasingly burdened in the years ahead. With current utilization, the National Center for Health Statistics estimates that the number of elderly persons residing in nursing homes will increase by 58 percent from 1978 to 2003 if constant mortality is assumed, and by more than 115 percent if declining mortality is assumed.[2] Not only will utilization increase, but those in nursing homes will be older and therefore more severely disabled. Researchers at the Brookings Institution estimate that in the years 2016-20, 51 percent of nursing home residents will be age 85 and older, compared to 42 percent in 1986-90.[3]

Analysis of nursing home utilization has found a high degree of variance in length-of-stay patterns among nursing home residents. The majority (75 percent) of persons entering a nursing home stay less than 1 year, and one-third to one-half stay for less than 3 months. Although only 5 percent of all older Americans are likely to be in a nursing home at any given time, those residents are more likely to be very old, female, and white. Residents age 85 and older comprise 45 percent of the nursing home population; 75 percent of elderly residents are female, and 93 percent are white.[4]

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[1] Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?* (Washington, D.C.: The Brookings Institution, 1988), p. 5-6.

[2] Changing Mortality Patterns. Health Services Utilization and Health Care Expenditures: United States 1978-2003, Analytical and Epidemiological Studies Series 3, No. 23, National Center for Health Statistics, Department of Health and Human Services, Pub. No. (PHS) 83-1407, September 1983. p. 20.

[3] Rivlin and Wiener, p. 11.

[4] National Center for Health Statistics, E. Hing: Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey. *Advance Data From Vital and Health Statistics.* No. 134. DHHS, Public Health Service. Washington, D.C., May 14, 1987.

TABLE 1.—NUMBER, PERCENT DISTRIBUTION, AND RATE OF NURING HOME RESIDENTS 65 YEARS OF AGE AND OVER BY AGE, SEX, AND RACE: UNITED STATES, 1985

Age, sex, and race	Number of residents	Percent distribution	Number of residents per 1,000 population 65 years nad over [1]
Total	1,315,800	100.0	46.1
AGE			
65-74 years	212,100	16.1	12.5
75-84 years	509,000	38.7	57.7
85 years and over	594,700	45.2	219.4
SEX			
Male	334,000	25.4	29.0
Female	981,000	74.6	57.7
RACE			
White	1,224,900	93.1	47.6
Black	82,000	6.2	35.0
Other	8,900	0.7	20.1

[1] Population data used to compute rates are from—U.S. Bureau of the Census: Estimates of the population of the United States by age, sex, and race: 1980 to 1985. Current Population Reports. Series P-25, No. 985. Washington. U.S. Government Printing Office, Apr. 1986.

Source: Chart from Esther Hing: "Use of Nursing Homes by the Elderly: Preliminary Data of Health and Human Services. Public Health Service. HCHS Advance Data. No. 135. May 14, 1987.

For women 85 years and older, their rate of nursing home use per 1,000 population is 248.9, compared to 13.8 for women age 65–74 and 66.5 for women age 75–84. A similar pattern exists for men, although their utilization rates are much lower. The greater likelihood of elderly white people to live in nursing homes is particularly true in the oldest age group. Of those age 85 and older, 23 percent of white people, compared to 14 percent of black people, resided in nursing homes.[5]

(B) HOME AND COMMUNITY-BASED CARE

For every person 65 and older residing in a nursing home, there are nearly four times as many living in the community requiring some form of long-term care. According to the Brookings Institution, there were approximately 4.9 million noninstitutionalized elderly residing in the community in 1985, which is about 18 percent of the over-65 population, that had limitations in ADLs and IADLs. About two-thirds of the 4.9 million disabled were moderately impaired (less than three ADL limitations).[6] About 850,000 elderly individuals were residing in the community with severe limitations (five or six ADLs).

Of the noninstitutionalized disabled elderly, about 75 percent relied exclusively on unpaid sources of home and community health care. Almost 1 million received at least some paid care and only 240,000 used paid care only. Of those who received both paid and unpaid care, nearly 41 percent were sole payers for this care. Medicare covered the cost of community care for 8.4 percent of this group and Medicaid paid for about 6 percent. Private insurance pays only about 1 percent of the Nation's long-term care bill.

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[5] National Center for Health Statistics, E. Hing, p. 3.
[6] Rivlin and Wiener, p. 6.

These figures illustrate the extent to which informal, family caregiving provide for the long-term care needs of the disabled elderly population. One study estimates that more than 27 million unpaid days of informal care are provided each week.[7] The majority of unpaid caregivers are women, usually wives, daughters, or daughters-in-law. Caring for a frail friend or family member places severe emotional and physical strain—and to a lesser degree, financial strain—on the caregiver. For example, according to the 1982 Long-Term Care Survey, 27 percent of caregivers surveyed reported that they were unable to leave their elderly disabled relatives at home alone, and 54 percent reported that their social life or free time had been limited by caregiving. However, only 15 percent said that their parents' care cost more than they could afford. Although most studies have found that worsening health is the primary factor precipitating institutionalization, the stresses associated with caregiving are often cited as a factor contributing to that decision.

Health care policymakers have recognized for some time the need to develop a more equitable balance between institutional and noninstitutional care. Most frail elderly in need of assistance with ADLs would prefer to receive that assistance in their homes. While nursing home care is a necessary part of the long-term care system, many feel it should be an option of last resort rather than first.

There is some disagreement as to whether home and community-based care is less costly than institutional care. Clearly in those instances where round-the-clock care is required, nursing home care is the more economical. However, many frail elderly persons need only intermittent care and assistance, which can be provided less expensively than nursing home care. Further, as the patient's needs for care and assistance change over time—as his or her health improves or worsens—home and community-based services are more flexible in adjusting the level of care needed by the patient.[8]

3. COVERAGE AND FINANCING

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance in-kind transfers, or the provisions of goods and services. Most of the public sector's expenditures for long-term care services, however, are for institutional care—primarily for nursing homes.

Data on total national spending for long-term care, from both private and public sources for institutional and noninstitutional care, are difficult to collect and quantify. Data released in 1988 by the Congressional Budget Office (CBO) represent the most recent attempt to estimate expenditures for long-term care. According to

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[7] Korbin Liu and Kenneth Manton, "Disability and Long-Term Care," paper presented at the Methodologies of Forecasting Life and Active Life Expectancy Workshop, Bethesda, MD, June 1985, p. 14. As cited in *Caring for the Disabled Elderly* by Alice Rivlin and Joshua Wiener (Washington, D.C.: The Brookings Institution), 1988, p. 5.

[8] Brian Burwell, "Home and Community-Based Care Options Under Medicaid," In *Affording Access to Quality Care*, ed. Richard Curtis and Ian Hill, (Washington, D.C.: National Governors Association, 1986).

CBO's estimates, total national spending on long-term care for all age groups was $44.9 billion in fiscal year 1985. Of this amount, $35.8 billion was for nursing home care, and $9.1 billion was for home health services (defined as nursing care, home health aides, medical social services, and speech, physical and occupational therapy). Direct, out-of-pocket payments covered 45 percent of the costs of nursing home care ($16.2 billion) and 40 percent of the costs of home health care ($3.7 billion). Private long-term care insurance paid only eight-tenths of 1 percent of the costs of nursing home care, and 4 percent of the costs of home health care.

CBO estimates that about 54 percent of nursing home expenditures were financed by Federal, State, and local governments. The remainder is financed primarily out-of-pocket. By far the largest portion of public expenditures for nursing home care is financed by the Medicaid Program. In fiscal year 1985, CBO estimates that Federal and State Medicaid expenditures for nursing home care amounted to an estimated $17.2 billion—representing approximately 48 percent of total national spending for nursing homes and 90 percent of public spending for nursing home care.

In contrast, Medicare accounts for only a small portion of the Nation's expenditures for nursing home care. According to CBO, Medicare's fiscal year 1985 expenditures amounted to $590 million and represented less than 2 percent of national spending and 3.1 percent of public spending for nursing home care.

About one-half of all long-term care costs are financed directly by the elderly and their families. Although the elderly will be better off financially in the coming years, there will also be increased numbers of them requiring some form of long-term care. The real incomes of those age 65–74 will more than double over the next 30 years because of higher pensions and increased Social Security benefits. For those age 85 and older (the group most at-risk of needing long-term care) however, the future is not quite so bright. Their income is expected to increase only 17 percent in the same time period. This group is already 50 years of age or older and therefore will not benefit from higher pension benefits or the increased participation of women in the work force.

Further, because long-term care costs are expected to rise more rapidly than the incomes of the old-old, those most likely to need long-term care in the future will be worse off financially than the elderly today—even though they will have higher incomes. For example, if nursing home costs rise 5.8 percent per year over the next 30 years, compared to 4 percent general inflation, spending on nursing home care will triple—from $33 billion in 1986–90 to $98 billion in 2016–20.[9]

Following is a discussion of the six primary sources of long-term care financing: Medicaid, Medicare, Social Service Block Grants, the Older Americans Act, Supplemental Security Income, and private sources of financing. No one of these programs provides a comprehensive range of long-term care services. Some provide primarily medical care, others focus on supportive or social services. The Medicaid Program, for example, has certain income and asset requirements, while the Medicare Program does not. Many advocates for the elderly contend that these differences reflect the fragmented and uncoordinated nature of the long-term care system in this country.

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[9] Rivlin and Wiener, p. 12.

(A) MEDICAID

(1) Coverage

Medicaid is a Federal-State entitlement program which provides medical assistance for certain low-income persons. Each State designs and administers its own Medicaid Program, setting eligibility and coverage standards within broad Federal guidelines. Although originally intended to provide basic medical services to the poor and disabled, Medicaid has also become the primary source of public funds for nursing home care. Approximately 90 percent of all public expenditures for nursing home care are paid by Medicaid and 50 percent of all nursing home residents use Medicaid as their primary source of payment.[10]

Medicaid is a means-tested entitlement program, which means that certain groups of persons (e.g., the aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children) qualify for coverage if their incomes and resources are sufficiently low. Medicaid beneficiaries are entitled to have payment made by the State for covered, medically necessary services. States then receive matching funds from the Federal Government to pay for covered services. There is no Federal limit on payments; allowable claims are matched according to a formula which takes into account a State's per capita income. Therefore, States with a higher per capita income will receive a lower percentage Federal matching and vice versa. The established minimum matching is 50 percent; the highest is 83 percent (although the highest rate currently in effect is 79.8 percent, in the State of Mississippi).

State Medicaid programs are required by Federal law to cover the categorically needy; that is, all persons receiving cash assistance under a welfare program (Aid to Families with Dependent Children (AFDC) and most people receiving assistance under the Supplemental Security Income (SSI) program). Eligible persons must meet the cash assistance program's definition of age, blindness, disability, or membership in a family with dependent children. Therefore, if a person does not fall into one of these categories, he or she is ineligible for Medicaid, regardless of income. Furthermore, people who fall into one of these categories must also meet specific income and resource standards, which vary from State to State.

In addition, States may, at their discretion, cover the optional categorically needy and the medically needy. Optional categorically needy programs extend Medicaid eligibility to those persons who are not receiving cash welfare assistance but who meet certain other criteria. Insofar as the elderly are concerned, optional categorically needy coverage enables persons living in institutions (e.g., nursing homes) to be covered by Medicaid if their incomes are low enough. Medically needy persons are defined as those whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but are not large enough to pay for their medical care. These State-by-State variations in eligibility can mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another.

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[10] National Center for Health Statistics: The 1985 National Nursing Home Survey, data from the National Health Survey. *Vital and Health Statistics*. Series 13, No. 97. DHHS Pub. No. (PHS) 89-1758. Public Health Service. Hyattsville, MD., January 1989.

A State may also, within Federal guidelines, define its own benefit package. Mandatory services include physicians' and hospital services, and care in a skilled nursing facility (SNF). Optional services include prescription drugs, eyeglasses, and services in an intermediate care facility (ICF) and services in an intermediate care facility for the mentally retarded (ICF/MR). States may also limit the coverage of all services; e.g., a limit on the number of hospital days. Reimbursement levels vary from State to State as well, so States vary widely in both the breadth and depth of their coverage.

Overall, Medicaid covers less than one-half of the population with incomes below the Federal poverty line. Approximately 41 percent of the poor were covered by Medicaid in 1986; the percentage varied by age with coverage extended to 52 percent of poor children, 34 percent of poor working age adults, and 31 percent of the poor elderly. However, although the elderly constitute only 14 percent of beneficiaries in fiscal year 1986, they accounted for 37 percent of total Medicaid spending.

Medicaid coverage for this population group is especially important since the elderly have great health care needs. Death rates among the elderly poor are 50 percent higher than for other Medicare beneficiaries. Despite their greater health needs, the elderly receive 35 percent fewer physician visits, use 29 percent fewer prescription drugs, and are 18 percent less likely to be admitted to a hospital than the rest of the population.

To control costs and to provide a range of community-based services to the Medicaid-eligible population, many States have applied to the Department of Health and Human Services (DHHS) for section 2176 Medicaid waivers. Congress established these waivers in 1981, giving DHHS the authority to waive certain Medicaid requirements to allow the States to broaden coverage to include a range of community-based services for persons who, without such services, would require the level of care provided in a SNF or an ICF. Services covered under the 2176 waiver include case management, homemaker, home health aide, personal care, adult day care, rehabilitation, respite, and others. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) established a new home and community-based services waiver program similar to the section 2176 program, but is available only to persons over age 65. While the waivers have been enthusiastically received by the States, there is concern about the administration's support for the 2176 waiver program, as is discussed later in this chapter.

(2) Expenditures

Medicaid expenditures for nursing home care in 1987 were approximately $17.8 billion. Medicaid accounted for 89 percent of public spending on nursing homes, and 44 percent of total nursing home expenditures.[11]

In 1972, elderly beneficiaries represented 19 percent of total program beneficiaries and accounted for 38 percent of program payments. Although the aged have declined as a proportion of total beneficiaries since that time, their proportion of total program payments has remained fairly constant. In fiscal year 1986, aged beneficiaries represented 14 percent of total Medicaid beneficiaries and their share of program payments amounted to 37 percent of total program payments.

The approximately 3.1 million elderly covered by Medicaid can be divided into three groups. The first is those elderly who have incomes low enough to qualify them for cash assistance; in other words, categorically needy. Fifty-four percent of elderly Medicaid beneficiaries (1.7 million) are categorically needy.

The second and third groups are composed of persons who do not receive cash welfare assistance. The second group, the optional categorically needy, is about 23 percent of elderly beneficiaries, or about 728,000 people. The third group is the medically needy, which accounts for another 23 percent, or approximately 732,000 people. These two groups include many persons using nursing home care. Many of these beneficiaries were not poor when they entered a nursing home; however, the high costs of nursing home care (in excess of $22,000 per year) result in many middle income elderly "spending down" their resources to Medicaid eligibility levels.

These different groups account for widely varying proportions of Medicaid spending for the elderly, largely as a result of their varying utilization of nursing home care, a costly service in and of itself. The categorically needy account for 25 percent of Medicaid expenditures for the elderly; the optional categorically needy, 33 percent; and the medically needy, 42 percent.

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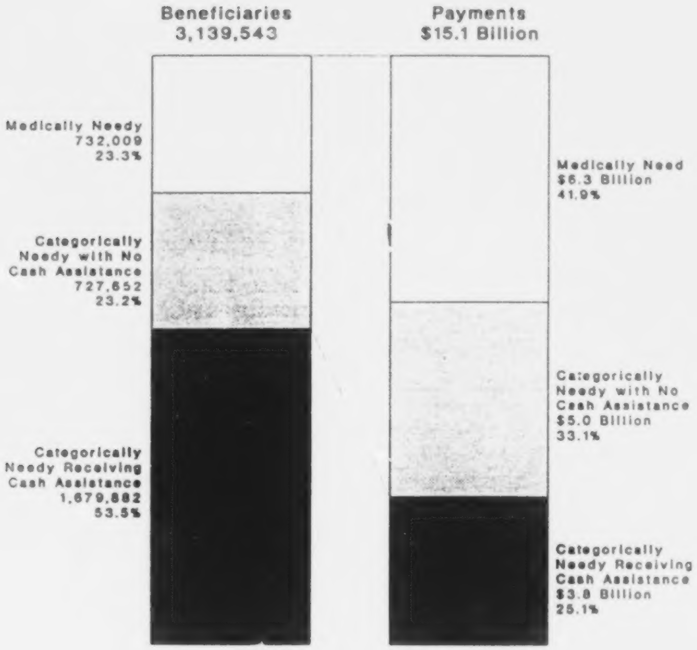
[11] Suzanne Letsch, Katherine R. Levit, and Daniel R. Waldo. "National Health Expenditures, 1987." *Health Care Financiing Review*, Winter, 1988, Vol. 10, No. 2, p. 19.

Aged Beneficiaries and Payments for Aged Beneficiaries By Eligibility Status, FY 1986



Source: HCFA-2082 forms. Figure prepared by Congressional Research Service, Education and Public Welfare Division.

Nursing home costs compose two-thirds of payments for elderly Medicaid beneficiaries. Seventy percent of the optional categorically needy and the medically needy elderly used nursing home services, accounting for 58 percent of all Medicaid payments for elderly beneficiaries. Nursing home payments were seven times as large a share of total payments for aged beneficiaries as they were for nonaged beneficiaries. Although this results in part because the elderly need and use more nursing home services than the nonelderly, it also reflects the fact that nearly all elderly Medicaid beneficiaries have Medicare as their primary payer of acute health care services. However, because Medicare provides extremely limited coverage of nursing home care, and there is virtually no private insurance available, Medicaid has become the primary source of public funds for nursing home care.

In contrast, expenditures for home care under Medicaid represent a small and static percentage of total program outlays. In 1986, Federal Medicaid expenditures for home health care were $1.4 billion, accounting for 3.3 percent of total Medicaid spending. For a variety of reasons, very few States have made extensive use of this benefit. The benefit itself is very limited, in that only medical services are covered. Furthermore, because services must be made available to all Medicaid beneficiaries, States have not been permitted to target services to specific populations, such as the elderly. Many States have taken up the slack and have funded home care out of State funds, or have established programs under the section 2176 waivers.

Medicaid's share of total national expenditures for nursing home care rose steadily since the program's inception in 1965, to a high of 48.6 percent in 1979. In the early 1980's, however, the percentage gradually declined, and appears to have leveled off in the past few years. This decline can be attributed to two factors: Cost containment measures, and a shift in the distribution of the Medicaid nursing home population from skilled nursing facilities to less-expensive intermediate care facilities. From 1977 to 1985, the number of SNF residents counted on 1 day increased from 260,000 to 263,000, and increase of 0.9 percent. However, the number of ICF residents increased from 362,600 in 1977 to 488,300 in 1985, an increase of 34.7 percent.[12]

There are a variety of cost containment measures taken by States to control their Medicaid expenditures. Most States use a form of prospective reimbursement for nursing home care. At least 30 States have instituted formal preadmission screening programs for their Medicaid eligible persons wishing to enter a nursing home. The purpose of these screening programs is to identify people who could be cared for in their own homes or in the community if appropriate services are available, and to assure that nursing home beds are available for those who truly need them. The certificate of need process, in which a provider had to apply to the State in order to expand or construct new beds or risk being ineligible for Medicare or Medicaid reimbursement, was seen as a Medicaid cost-containment measure in some States.

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[12] *Medicaid Source Book: Background Data and Analysis.* Report prepared by the Congressional Research Service for the use of the Subcommittee on Health and the Environment, Committee on Energy and Commerce. (Committee Print 100-AA). Washington, D.C.: GPO, November 1988, p. 470

(B) MEDICARE

(1) Coverage

The Medicare Program, which insures almost 98 percent of all older Americans without regard to income or assets, primarily provides acute care coverage for those 65 and older, particularly hospital and surgical care and accompanying periods of recovery. Medicare does not cover either long-term or custodial care. However, it does cover care in a skilled nursing facility (SNF), home health care, and hospice care in certain circumstances.

The Skilled Nursing Facility Benefit.—In order to receive reimbursement under the Medicare SNF benefit, which is financed under Part A of the Medicare Program, a beneficiary must be in need of skilled nursing care on a daily basis for an acute illness. The program pays for neither intermediate care facility services nor custodial care in a nursing home

Although the Medicare Catastrophic Care Act (MCCA) expanded the Medicare SNF benefit, the repeal of that law in late 1989 restores the old benefits. The SNF benefit will be tied once again to the "spell of illness" which begins when a beneficiary enters the hospital and ends when he or she has not been an inpatient of a hospital or SNF for 60 consecutive days. A beneficiary is entitled to 100 days of SNF care per spell of illness, following a 3-day prior hospitalization, a requirement that was reinstituted when the MCCA was repealed. Days 21-100 are subject to a daily coinsurance charge ($74 in 1990) equal to one-eighth of the hospital deductible. In comparison, the MCCA provided up to 150 days of SNF care per year, with a copayment equal to 20 percent of the average per diem SNF rate for the first 8 days of care.

In 1987, there were 327,000 SNF admissions, and Medicare covered an average of 21.5 days of care, compared to 273,000 admissions in 1981 at an average of 29.2 days.[13] This decline is a result of both an increase in shorter SNF stays and a decrease in longer SNF stays; from 1983 to 1985, SNF stays with 7 or fewer covered days increased more than 56 percent and SNF stays with 31 or more covered days decreased 18 percent. The use of the SNF benefit per enrollee has remained fairly constant in the years 1981-87, at 10 per 1,000 enrollees. Covered charges for aged beneficiaries in that time period increased 70 percent, from $670 million to $1.2 billion.[14]

One factor that may have had an impact on the length of covered SNF stays is the amount of the deductible, which in many cases exceeds the facility's regular daily charge [15] Medicare's Prospective Payment System (PPS), with its incentives to discharge patients as soon as medically feasible, has also had an impact on the use of the SNF benefit.

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[13] Viola B. Latta and Roger E. Keene. "Use and Cost of Skilled Nursing Facility Services under Medicare, 1987," *Health Care Financing Review*, Vol. 11, No. 1, Fall, 1989, p. 105.

[14] Latta and Keene, *Health Care Financing Review*, p. 108.

[15] Latta and Keene, *Health Care Financing Review*, p. 104.

The Home Health Benefit.—Both Part A and Part B of the Medicare Program cover home health services without a deductible or coinsurance charge. There is no statutory limitation on the number of home health visits covered, and no prior hospitalization requirement. The Medicare home health benefit is only for short periods of care and only for treatment of an acute care condition or for post-acute care. Below is a brief description of Medicare's home health benefit; developments with regard to this program are discussed in greater detail in Chapter 7.

Home health services covered under Medicare include the following:

—part-time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;
—physical, occupational, or speech therapy;
—medical social services provided under the direction of a physician;
—medical supplies and equipment (other than drugs and medicines);
—medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency; and
—part-time or intermittent services provided by a home health aide, as permitted by regulations.

To qualify for home health services, the Medicare beneficiary must be confined to the home and under the care of a physician. In addition, the person must need part time or intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. The patient is not subject to any cost-sharing, such as deductibles or coinsurance, for covered home care. Although there is no limit on the number of covered visits, program guidelines generally limit daily home health care to 5 days per week for 2 to 3 weeks.

The Hospice Benefit.—Medicare also covers a range of home care services for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, outpatient drugs, therapy services, medical social services, home health aide services, physician services, counseling, and short-term inpatient care. A Medicare beneficiary who elects hospice care waives entitlement to Medicare benefits related to the treatment of the terminal condition or related conditions, except for the services of the patient's attending physician. Payments to providers for covered services are subject to a cap, which was $9,010 in hospice year November 1, 1988 to October 31, 1989, and enrollees are liable for copayments for outpatient drugs and respite care. Coverage for hospice services is subject to a lifetime limit of 210 days.

(2) Expenditures

Medicare expenditures for these services generally have been small. In 1987, Medicare's covered charges for SNF care were $1.2

billion, which represents a little more than 2 percent of total public and private spending for nursing home care and approximately 1.5 percent of total Medicare spending.[16] Medicare payments for home health care in 1987 were $2.5 billion, which is about 3.8 percent of total program outlays.[17] Expenditures for hospice care in fiscal year 1990 were estimated to be $180 million.

(C) TITLE XX

(1) Coverage

Title XX of the Social Security Act authorizes reimbursement to States for social services, now distributed via the Social Services Block Grant (SSBG). Among other goals, the SSBG is designed to prevent or reduce inappropriate institutional care by providing for community-based care, and to secure referral or admission for institutional care when other forms of care are not appropriate.

Although the SSBG is the major social services program supported by the Federal Government, its ability to support the long-term care population is limited. Because it provides a variety of social services to a diverse population, the Title XX program has competing demands and can only provide a limited amount of care to the older population.

Prior to 1981, States were required to make public a report on how SSBG funds were to be used, including information on the types of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated, and as a result, data concerning the extent to which Title XX now supports long-term care are very limited. According to a Department of Health and Human Services analysis of the States' fiscal year 1988 pre-expenditure reports, home care services, which may include homemaker, chore, and home management services, were to be provided to adults and children by virtually all States.

(2) Expenditures

States receive allotments of SSBG funds on the basis of the State's population, within a Federal expenditure ceiling. There are no requirements for use of Title XX funds—States are provided relative freedom to spend Federal Social Service Block Grant funds on State-identified service needs. In fiscal years 1985, 1986, and 1987, the appropriation level was $2.7 billion; the 1988 appropriation was raised slightly to $2.75 billion. Appropriations in 1989 were $2.7 billion. The expenditure ceiling in for fiscal year 1990 was raised to $2.8 billion. Final amounts available for fiscal year 1990 were reduced, however, as a result of the sequestration of funds under the Gramm-Rudman deficit reduction legislation.

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[16] Latta and Kenne, *Health Care Financing Review*, Fall, 1989, p. 108; and, Letsch, Levit, and Waldo, *Health Care Financing Review*, Winter, 1988, p. 119.

[17] Committee on Ways and Means, U.S. House of Representatives. *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*. Committee Print 101-4, 101st Congress, 1st Session. (Washington, D.C.: U.S. Government Printing Office), March 15, 1989, p. 142.

(D) THE OLDER AMERICANS ACT

(1) Coverage

The Older Americans Act (OAA) carries a broad mandate to improve the lives of older persons in the areas of income, social services, emotional and physical well-being, housing, employment, civic, cultural, and recreational opportunities. While the OAA funds a wide range of supportive services, in-home services such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance have been given explicit priority by Congress. Each OAA area agency on aging is required to spend a portion of its supportive services allotment on home care services.

The number of home care visits to older persons under the OAA represents only a small fraction of the amount provided under Medicare and Medicaid. The OAA services, however, are provided without the restrictions called for by Medicare and without the income tests called for by Medicaid. In some cases, OAA funds may be used to assist persons whose Medicare and Medicaid benefits have been exhausted or who are ineligible for Medicaid.

Congress recognized the growing need for in-home services when it amended the OAA to expand in-home services authorized under Title III. The Older Americans Act Amendments of 1987 (P.L. 100-175) added a new Part D to Title III, authorizing grants to States for nonmedical in-home services for frail older persons. These services include assistance in such areas as bathing, dressing, eating, mobility, or performance of daily activities such as shopping, cooking, cleaning, or managing money. In-home respite care for families and visiting and telephone reassurance are additional examples of allowable services.

Funding for this new program is aimed at assisting persons who are ineligible for other Federal programs. Currently, many frail elderly persons who are not poor enough to qualify for Medicaid and who do not meet Medicare's medical-related criteria need in-home services to live independently. These new OAA services are targeted strictly at the elderly and may be provided without the health-related restrictions of Medicare and the income tests of Medicaid.

(2) Expenditures

Unlike the Title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of Title III funds for supportive services, for congregate nutrition services and for home-delivered nutrition services. States receive allotments of these funds according to the number of older persons in the State as compared to all States. The law gives States and area agencies on aging some flexibility to define the supportive services to be provided and to transfer funds among the three service categories. Total fiscal year 1989 appropriations for Title III were $858 million, including $356.7 million for congregate nutrition services, $275.7 million for supportive services and senior centers, $78.5 million for home-delivered nutrition services, $141.3 million for USDA commodities, $4.8 million for in-home services for the frail elderly, and $988,000 for the long-term care ombudsman program. For fiscal year 1990, post Gramm-Rudman sequestration appropriations for Title III are $853.1 million, including $351.9 million for congregate nutrition services, $272 million for supportive services and senior centers, $79 million for home-delivered nutrition services, $143.5 million for USDA commodities, $5.8 million for in-home services for the frail elderly, and $974,000 for the long-term care ombudsman program.

(E) PRIVATE INSURANCE

(1) Medigap

The term "medigap" is commonly used to describe a private health insurance policy that is typically designed to supplement Medicare's coverage of acute care costs, not long-term care costs. Following is a brief overview of medigap insurance; for a more detailed discussion of this subject, please see Chapter 7.

Although there is no ongoing survey that collects information about medigap coverage, several studies have been done by various groups in recent years. In general, one can conclude from them that approximately 70 to 80 percent of aged Medicare beneficiaries (about 20 million persons) have some other type of health insurance policy, although not all of it is medigap insurance. About 40 percent of those with Medicare (about 11 million persons) purchase some type of private health insurance, most of which is probably medigap insurance. Another 30 to 35 percent (about 8 million persons) have employment-based coverage, and probably less than half of it could be considered medigap coverage.

Most policies provide comprehensive coverage for Medicare copayments but very few provide coverage for needed services and products that Medicare does not cover. A 1987 fact sheet from The Blue Cross and Blue Shield Association on the Blue Plans' nongroup medigap policies indicated that 86 percent covered SNF coinsurance for days 21-100, and 36 percent covered SNF days after the expiration of the 100-day benefit. The value of medigap coverage for long-term care of a chronic illness, however, is very limited. These policies generally cover a very small fraction of total nursing home costs and an even smaller portion of home health or custodial care costs.

Premiums for medigap coverage vary greatly according to geographic location and age, as well as the extent of benefits covered, administrative costs, company profit, etc. A telephone survey conducted by the Health Insurance Association of America (HIAA) in 1987 found that the mean 1989 annual medigap premium was $718 and the median was $640.[18] It is important to note, however, that 1989 premiums were based on policies that included fewer benefits because of the more extensive coverage offered by the Medicare Catastrophic Care Act. According to the General Accounting Office, the recent repeal of MCCA will result in an increase of 18 percent over the average 1989 medigap premium.[19]

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[18] Rice, Thomas, Catherine Desmond, and Jon Gabel. *Older Americans and Their Health Coverage.* Health Insurance Association of America Research Bulletin, October 1989.

[19] U.S. General Accounting Office. *Medicare Catastrophic Act: Estimated Effects of Repeal on Medigap Premiums and Medicaid Costs.* GAO-HRD-90-48FS, Washington, D.C., November 1989.

The above-mentioned HIAA study found that there were several factors relating to the likelihood of an older person having medigap insurance. Those persons age 80 and under, whites, married, better educated, higher incomes, and those reporting better health status were all most likely to have one or more supplemental insurance policy. The differences were not great for most factors, with the exception of race: While 82 percent of whites had policies, only 33 percent of nonwhites did. Although income was not a factor above $10,000, data from CBO found that in 1984, only about 44 percent of the elderly with incomes below $5,000 had private supplemental insurance, compared to 87 percent of those with incomes of $25,000 and over.[20] Therefore, while medigap policies provide some needed protection for many of our Nation's elderly, those who have the greatest need for coverage often go without it.

(2) Long-Term Care Insurance Policies

The financing of long-term care through private long-term care insurance has been receiving a great deal of attention recently. This is occurring not only because of growing concerns about public program expenditures, but also because the costs of long-term care represent the largest out-of-pocket health expense for the elderly. To date, however, very few older Americans have purchased this type of coverage. According to HIAA, as of June 30, 1989, there were some 100 companies writing long-term care insurance policies covering approximately 1.3 million people.

There have been numerous problems associated with the development of long-term care insurance that is both affordable and offers broad coverage. In 1987, the General Accounting Office (GAO) released a report on the private long-term care insurance market.[21] GAO reviewed 33 policies offered by 25 insurers, accounting for a sizable portion of the policies sold nationwide. There was considerable variation among the policies—for example, the indemnity benefit amounts (fixed dollar amount paid per eligible day of coverage) ranged from less than $10 to $120 per day. Premiums charged varied from $20 to $7,000 per year, offering varying levels of coverage at different ages. Duration of benefits differed widely as well—6 months to 6 years of nursing home care and 10 days to 6 years for home health services.

GAO found that in general, premiums increased with age, and insurers offered indemnity benefits that were not indexed to keep pace with inflation. Most of the policies GAO reviewed contained restrictive clauses (such as requirements that policyholders be admitted to nursing homes within 30 days of hospital discharge) and limitations (such as exclusions from certain diseases) that might prevent some policyholders from collecting benefits.

However, GAO also found that more insurers offer custodial care benefits, and nearly half of the policies reviewed provide benefits for all levels of nursing home care and home care benefits. Most of the policies let consumers choose the length of the waiting period and daily indemnity amounts from among several options. Most of the policies also guarantee renewability. However, since the insurers who guarantee renewability reserve the right to raise premiums for a class of insured, some elderly policyholders on fixed incomes could be priced out of the market.

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[20] Prospective Payment Assessment Commission. *Medicare Prospective Payment and the American Health Care System: Report to Congress*, June 1989, p. 80. From Congressional Budget Office calculations based on the Survey of Income and Program Participation and the 1980 National Medical Care Utilization and Expenditure Survey.

[21] U.S. General Accounting Office. *Long-Term Care Insurance: Coverage Varies Widely in a Developing Market*. GAO/HRD-87-80, Washington, D.C., May 1987.

More recently, the Washington, DC-based United Seniors Health Cooperative released a study in 1988 that examined the coverage provided by 77 private long-term care insurance policies. The study found that most plans have restrictions, such as prior hospitalization or prior skilled care, that severely limit the beneficiary's ability to collect any benefits. The average probability of not collecting benefits from a policy was 61 percent, if the beneficiary were admitted to a nursing home.[22] Furthermore, two-thirds of the plans did not offer benefits that increased with inflation. The most common type of nursing home coverage was a $50 per day indemnity benefit, an amount which the study found to be "grossly inadequate" to meet the expected costs of care in the future.[23]

The researchers also found shortcomings in those plans that offered home health care coverage, particularly the requirement for a prior stay in a nursing home. According to the study, this requirement in effect prevents most policyholders from collecting any benefits. Because eligibility for home care benefits is contingent on one's chances of both entering a nursing home and then returning home, as well as meeting a deductible and often a minimum stay requirement, most policyholders have about a 5 percent probability of collecting benefits.[24]

A number of barriers have been cited as impediments to the development of long-term care insurance policies. Many insurers are concerned about adverse selection, in which only persons more likely to need long-term care will buy insurance for it. Induced demand—beneficiaries using more services because they have insurance and/or shifting from unpaid to paid providers for their care—is another concern. Further, many people who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

In 1985, at congressional request, the Department of Health and Human Services (DHHS) established a Task Force on Long-Term Health Care Policies. In 1987, the task force released its report to Congress and the Secretary of DHHS. The report contained recommendations for encouraging the development of a broad-based market for affordable long-term care policies while providing reasonable protection for consumers. Recommendations included expansion of the market through employer-sponsored long-term care insurance, the creation of tax incentives to encourage participation by both employers and insurance companies, long-term care financing through vested pension funds, the development of new approaches to eligibility requirements for long-term care insurance benefits, and efforts to educate the public on its need for this type of coverage.

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[22] James P. Firman, William G. Weissert, and Catherine E. Wilson, *Private Long-Term Care Insurance: How Well Is It Meeting Consumer Needs and Public Policy Concerns?*, (Washington, DC: United Seniors Health Cooperative, 1988), p. 24.

[23] Firman, Weissert, and Wilson, p. 30.

[24] Firman, Weissert, and Wilson, p. 38.

Another approach being considered by some health policymakers to encourage the development of private long-term care insurance is "stop-loss" coverage. This approach defines in advance what an insurance company's cost liability would be. For example, persons requiring nursing home care would be responsible for covering the costs of the first 2 or 3 years of care, and would presumably buy an insurance policy to provide that protection. After that time period had expired, the Federal Government would then begin to cover the costs of care. This approach would not only limit Federal and private insurance liability, but would also prevent persons from depleting their resources as is currently the case with Medicaid.

The private insurance industry has expressed reservations about this approach, as it does not believe that the Federal Government covering the costs of the longest-stay nursing home patients would have a significant impact on the costs of premiums. Rather, they contend that the age of purchase has a greater impact on premium cost than duration of coverage. According to the insurance industry, if younger persons purchase policies, the size of the pool sharing the risk is enlarged and reserves can be accumulated over long periods.

Despite the problems inherent in this area, many believe that significant market development may occur in the next several years. Not only is there growing interest on the part of some insurance companies, but many States, faced with mounting Medicaid nursing home expenditures, have expressed interest in having such coverage made more widely available.

(F) OUT-OF-POCKET COSTS

While the cost of long-term care represents an increasing share of Federal and State budgets, relatively few older Americans have access to publicly financed services. The cost of nursing home care and home and community-based care often falls on individuals and their families.

Most older persons and their families pay for nearly one-half of the costs of nursing home care directly out of their own pockets. In 1987, 49.3 percent of the costs of nursing home care for all age groups (about $20 billion out of a total of $40.6 billion) were paid out-of-pocket.[25] For those age 65 and older, of the $32.8 billion spent on nursing home care for that age group in 1987, nearly 60 percent was from private sources, most of which is direct out-of-pocket payments.[26] Further, the proportion of total nursing home costs paid out-of-pocket has increased by nearly 14 percent from 1980 to 1987. During that same period, the portion of nursing home costs paid by Medicaid has actually decreased, from 48 percent in 1980 to 44 percent in 1987. While the amount that Medicaid pays for nursing home care has increased 81 percent between 1980 and

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[25] Letsch, Levit, and Waldo, *Health Financing Review*, p. 119.

[26] Waldo, Daniel R., Sally T. Sonnefeld, David R. McKusick, and Ross H. Arnett III. "Health Expenditures by Age Group, 1977 and 1987." *Health Care Financing Review*, Summer 1989, Vol. 10, No. 4, p. 167.

1987, the amount paid out-of-pocket was nearly 125 percent in that same time period.[27]

The vast majority of the chronically ill and disabled elderly population rely exclusively on informal support. Between 70 percent and 80 percent of the elderly persons living in the community who need long-term care receive it from family and friends. The remaining 20 to 30 percent pay for their care themselves, or have some or all of their care paid for by private insurers, Medicare or Medicaid, and family members.[28] Of the total $9.1 billion spent on home health care in the United States in 1985, $3.7 billion, or 40 percent, was paid out-of-pocket.[29] Home care is generally a less-expensive option for the elderly, but about 14 percent have out-of-pocket costs from home care that range from $360 to $1,680 per year, depending on the level of disability.[30] These out-of-pocket costs are only for home health care; they do not include other health-related expenses, such as prescription drugs, or the other community-based services needed by many functionally impaired individuals.

The cost of community-based care pales in comparison with the cost of nursing home care. The price of a year in a nursing home ranges from $12,000 to $50,000; the cost at even the lower end of this range is beyond the resources of many older Americans. Thus, many elderly people must spend their entire savings and become eligible for Medicaid soon after they enter a nursing home. Currently, between one-quarter and two-thirds of the patients who enter nursing homes as private paying patients subsequently spend down their resources and become eligible for Medicaid. A 1987 study released by the House Select Committee on Aging shows that this spend-down occurs on average within 13 weeks after admission for the single older American.[31]

B. ISSUES AND LEGISLATION

1. Nursing Home Care

The demand for nursing home services is expected to escalate over the next several years because of growth of the population of older Americans. The 65 and older age group is expected to increase from the present level of 25 million to 36 million by the year 2000. More notably, the 85 and over population (those most at risk of needing institutional care) is expected to increase from 2.5 million at the present time to 5 million in the year 2000—an increase of 100 percent.

As interest in providing comprehensive long-term care services to our Nation's elderly continues to grow, it is likely that issues surrounding nursing home care will become the focus of increased congressional and public attention in the years to come. Following is a discussion of several of the pertinent nursing home issues of the past few years, including: Nursing home quality of care and the Omnibus Budget Reconciliation Act of 1987; Medicaid coverage for the improverished aged, including Medicaid spend-down and spousal impoverishment; the personal needs allowance for Medicaid nursing home residents; and the long-term care ombudsman program under the Older Americans Act.

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[27] Letsch, Levit, and Waldo, p. 119.

[28] Callahan, et al., 1980; Christianson and Stephens, 1984; Liu et al., 1986; as cited in Stone, Cafferata, Sangl, Caregivers of the Frail Elderly: A National Profile.

[29] Congressional Budget Office, 1988.

[30] 1982 National Long-Term Care Survey.

[31] U.S. Congress, House of Representatives, Select Committee on Aging. "Long-Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are At Risk." Comm. Pub. 100-631. U.S. Government Printing Office: Washington, D.C., October 1987.

(A) NURSING HOME QUALITY OF CARE AND OBRA 1987

Quality of care in nursing homes has been an item of great concern to the elderly and their advocates for a number of years. During the 1980's, several investigations and studies, including a 2-year investigation (completed in 1986) by the Senate Special Committee on Aging,[32] a report by the General Accounting Office,[33] and a report by the Institute of Medicine [34] found that thousands of frail elderly citizens live in nursing homes which fail to provide care adequate to meet even their most basic health and safety needs. Legislation was passed in 1987 to implement many of the recommendations of the various studies and aging advocacy organizations. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) contains extensive nursing home quality care provisions that will take effect over 2½-year period. This legislation will be outlined in greater detail below, following a discussion of the findings that led to its passage.

In 1982, in response to congressional concern about controversial nursing home regulations proposed by the Health Care Financing Administration (HCFA) to essentially "deregulate" the nursing home industry, HCFA commissioned a study from the Institute of Medicine (IoM) of the National Academy of Sciences. According to the contract, this study was to "serve as a basis for adjusting Federal (and State) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible." The study was begun in October 1983 and released in 1986. It concluded that the quality of care and quality of life in many nursing homes are unsatisfactory, and that a stronger Federal role is essential to improve the quality of care. The study made a number of recommendations to strengthen and improve the current Federal regulations that were incorporated into the 1987 law. These recommendations included the elimination of the distinction between SNFs and ICFs, the use of intermediate sanctions to enforce compliance with regulations, and the strengthening of residents' rights.

The Special Committee on Aging's investigation found many of the same problems. For example, the Aging Committee disclosed that nursing home inspection reports from HCFA revealed that in 1984, more than one-third (3,036) of the Nation's 8,852 certified SNFs failed to comply with the most essential health, safety, and quality standards of the Federal Government. About 1,000 (11 percent) of the SNFs violated three or more of these standards. GAO found that 41 percent of SNFs and 34 percent of ICFs nationwide were out of compliance during three consecutive inspections with 1 or more of the 126 skilled or 72 intermediate care facility requirements considered by experts to be most likely to affect patient health and safety. Penalties or sanctions to enforce the compliance were found to be severely lacking.

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[32] U.S. Senate, Special Committee on Aging. *Nursing Home Care: The Unfinished Agenda.* S. Prt. 99-160, U.S. Government Printing Office: Washington, D.C., May 1986.

[33] U.S. General Accounting Office. *Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed.* GAO-HRD-87-113, Washington, D.C., May 1987.

[34] Institute of Medicine, National Academy of Sciences. *Improving the Quality of Care in Nursing Homes.* National Academy Press; Washington, D.C., 1986.

In 1987, Senator Mitchell and Representatives Dingell, Waxman, and Stark introduced comprehensive nursing home reform legislation, components of which were included in the Omnibus Budget Reconcilation Act of 1987 (P.L. 100-203). The OBRA 1987 reforms were the result of a virtually unprecedented consensus of Congress, consumers', and nursing home provider groups, professional associations, and aging advocacy organizations. The provisions were written in great detail, similar to agency regulations, leaving little to interpretation. Many contend that this reflected congressional distrust of HCFA and the Reagan Administration on this issue. In October and November 1987, HCFA had issued two sets of proposed rules to address nursing home quality concerns in what many believe was an attempt to illustrate that legislation was not needed.

Below are highlights of the OBRA 1987 nursing home reform provisions. Please note that the implementation dates below are from OBRA 1987, and some have been changed by subsequent legislation, which is discussed later in this section.

Definition of a Nursing Facility.—Eliminates the distinction between SNFs and ICFs as of October 1, 1990, and repeals a requirement that States pay less for ICF services than for SNF services; as of October 1, 1990, all nursing homes participating in either Medicare or Medicaid must meet the same requirements for provision of services, the rights of residents, staffing and training, and other administrative matters.

Requirements for Care.—As a condition of participation in Medicare and Medicaid, facilities must, at least once a year, conduct a comprehensive assessment of each patient's ability to perform every day activities such as bathing, dressing, eating, and walking. Results of such assessments will be used in a written plan of care, describing how a person's medical, psychological, and social needs will be met.

After January 1, 1989, nursing homes are prohibited from admitting residents who are mentally ill or mentally retarded unless they also require the level of care provided in the facility. Preadmission screening must be completed on all prospective residents, whether the costs of care are covered by private or public sources.

Residents' Rights.—Requires that nursing home residents be informed both orally and in writing of their legal rights, including the rights to: Choose a personal physician, and be informed in advance about treatment; be free from physical or chemical restraints; have privacy in accommodations, medical treatment, written and telephone communications; confidentiality of personal and clinical records; and have immediate access to a State or long-term care ombudsman.

Staffing Requirements.—As of October 1, 1990, all nursing facilities participating in Medicare and Medicaid must have at least one registered nurse on duty 8 hours per day, 7 days per week, and at least one licensed nurse on duty, 24 hours per day, 7 days per week. All nursing facilities with more than 120 beds must employ at least one full-time social worker.

Training for Nurse Aides.—All nurse aides in facilities participating in Medicare and Medicaid must complete an approved training course (75 hours) that includes instruction in basic nursing skills, personal care skills; cognitive, behavioral, and social care; and residents' rights. States must maintain a registry of individuals who have successfully completed such a course, and must also report instances in which the aide has committed acts of resident neglect or abuse (although the aide will have appeal rights).

Survey and Certification Process.—States are responsible for ensuring compliance with new requirements (except State-owned facilities, which would be monitored by the Federal Government). Each facility is subject to an unannounced "standard survey" on a statewide average of at least one per year, but no less than every 15 months. Facilities found to be delivering substandard care will be subject to an "extended" survey. However, States may impose sanctions based solely on the results of a standard survey.

States also must maintain procedures and staff adequate to investigate complaints of violations of requirements, and to monitor on site, on a regular basis, the compliance of facilities found in violation or suspected of violations.

Enforcement Process, Intermediate Sanctions.—If a State or the Federal Government finds a facility out of compliance and the deficiencies immediately jeopardize the health or safety of the residents, the State or DHHS must take immediate action to correct the deficiencies through the appointment of temporary management or terminate the facility's participation in the Medicare or Medicaid Program.

If the facility's deficiencies do not immediately jeopardize the health or safety of its residents, the State or DHHS may impose one or more intermediate sanctions, terminate the facility's participation or both. Intermediate sanctions include denial of payment for new Medicare or Medicaid admissions, civil penalties for each day of noncompliance, appointment of temporary management for the facility, and emergency authority to close the facility and transfer its residents.

Facilities found out of compliance for 3 consecutive months are automatically subject to denial of payment for new admissions. Facilities remaining out of compliance for three consecutive standard surveys and found to be delivering substandard care are subject to automatic denial of payments and to on-site monitoring by State officials.

(B) ISSUES IN THE IMPLEMENTATION OF OBRA 1987

(1) The February 2, 1989, Final Rule

Since the passage of OBRA, the biggest stumbling block that groups representing nursing home residents and providers have encountered is HCFA's implementation of the law. On February 2, 1989, HCFA published in the Federal Register "Medicare and Medicaid Requirements for Long-Term Care Facilities: Final Rule with Request for Comments." According to HCFA, these final rules "reflect . . . the comments on the NPRM [the proposed rule published by HCFA in October 1987, prior to the passage of OBRA 1987] and the requirements of OBRA 1987." The aforementioned NPRM had been a point of contention between HCFA and various aging advocacy groups from the beginning, as many believe it was developed in opposition to anticipated OBRA reforms. Final passage of OBRA occurred after the comment period on the NPRM expired, and critics contended that because OBRA so fundamentally changed HCFA's regulatory mandate, HCFA should have reopened the rulemaking process. HCFA, however, disregarded this criticism, and stated that these new requirements, most effective August 1, 1989, were a "bridge to the new requirements of OBRA 1987 that are effective in 1990."

Most aging advocacy and provider groups disagreed with HCFA on a number of points. They believed that through the February 2 rule, HCFA was attempting to implement portions of OBRA 1987 that were not effective until October 1990, and without providing an opportunity for public comment. They also argued that many of the regulations were inconsistent with OBRA 1987.

Furthermore, OBRA established deadlines for the Secretary to meet in issuing regulations to implement various provisions of the law. To date, the Secretary has missed nearly every deadline. This is a matter of concern to many groups not only because OBRA requires States to implement the law whether or not they have received guidance from DHHS, but also because many groups felt that the Secretary should be focusing on issuing these regulations, rather than developing others for which the deadline was several months away.

A coalition of nursing home consumer groups asked HCFA to delay implementation of the regulation. The Gray Panthers, nursing home residents from three States, and the District of Columbia filed a suit asking a Federal court to declare the final regulations illegal. In May 1989, the Senate Special Committee on Aging held a hearing to examine HCFA's role in the implementation of the OBRA. At that hearing, HCFA indicated that they would likely delay the implementation of the February rule. On July 14, 1989, HCFA published a notice that it would delay implementation until January 1, 1990. Subsequently, the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) further delayed implementation until October 1, 1990.

(2) Preadmission Screening and Annual Resident Review

OBRA 1987 requires preadmission screening of mentally ill and mentally retarded nursing home applicants to determine if they need the care that a nursing home provides, and, if so, whether they need active treatment. It also requires an annual review of mentally retarded or mentally ill residents to ensure that their continued placement in a nursing home is appropriate. Those suffering from Alzheimer's disease are excepted from this process, otherwise known as PASARR. OBRA 1987 required that prospective applicants be screened beginning January 1, 1989, regardless of whether the Secretary had promulgated regulations; by April 1, 1990, all such residents who have lived in a nursing home for less than 30 months must be placed elsewhere. Nursing homes that do not comply are subject to a cutoff of all Medicare and Medicaid funds.

This provision was intended to ensure that the mentally ill and mentally retarded get the specialized treatment that they need. It was the hope of those developing the legislation to foster the growth of community-based centers such as group homes and halfway houses that many States have been slow to encourage. Unfortunately, it is causing a great deal of consternation among State regulatory agencies as well as among industry and consumer groups for a variety of reasons. While there is agreement that nursing homes are not the most appropriate placement for the mentally disturbed, Medicaid has always paid for their care there. It traditionally does not cover care in other, more suitable settings, such as the aforementioned group homes and halfway houses. The problem is often a result of a lack of funding for this type of care at the State and local levels. However, even if sufficient funding can be found, there are fears that States will not be able to provide services for all those who will need assistance in the alloted time frame.

Another significant problem is the absence of any substantive guidance from HCFA on the PASARR process. OBRA 1987 required HCFA to develop the PASARR criteria by October 1988. These criteria would provide, among other things, a definition of mental illness and mental retardation. To date, HCFA has yet to release anything but interim guidelines to the States to use for screening and review, the most recent being in May 1989.

At the Senate Aging Committee's May 1989 hearing on OBRA implementation, various witnesses pointed out that the various drafts from HCFA on PASARR differed in their definitions of mental illness and active treatment and the services that States must provide to those who need this level of care. They expressed concern that once the guidelines are published as regulations, they will have to redesign their screening and resident review programs. Nursing home provider groups also objected to the application of PASARR to all persons, regardless of whether they are private payers, Medicare beneficiaries, or Medicaid-eligible persons, so long as they were applying for admission to, or residing in, a Medicaid-certified nursing home.

OBRA 1989 requires the Secretary to issue proposed regulations on PASARR within 90 days of enactment of the law (it was signed into law on December 19, 1989).

(3) Nurse Aide Training

The IoM report found that over 70 percent of the nursing personnel in long-term care facilities are nurse aides, and as much as 90 percent of resident care is delivered by them.[35] For this reason, the

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[35] *Improving the Quality of Care in Nursing Homes*, p. 89, 90.

IoM recommended that the Federal Government mandate the training of nurse aides prior to their employment. As a result, OBRA 1987 established new requirements for nurse aide training. OBRA 1987 stated that for those nurse aides hired prior to July 1, 1989, nursing homes participating in Medicaid and/or Medicare must provide a competency evaluation program and the preparation necessary to for the aide to complete this program by January 1, 1990. For newly hired nurse aides, the law requires that they complete both a training program and a competency evaluation. The training program must include a minimum of 75 hours of initial training. Training and evaluation programs may include those offered by or in nursing homes. OBRA 1987 also requires that Medicare and Medicaid recognize the costs of nurse aide training incurred by facilities. The Secretary was required to establish requirements for approval of these programs by September 1, 1988. To date, HCFA has issued only temporary guidance pending the issuance of regulations.

OBRA 1989 includes several provisions to address nurse aide training. It requires the Secretary of DHHS to issue proposed regulations to implement the nurse aide training requirements within 90 days of enactment of OBRA 1989. It delays from January 1, 1990 to October 1, 1990, the date by which aides must complete training and/or competency evaluation programs and be determined qualified to provide care. It also requires nurse aide training programs to include instruction in the care of cognitively impaired persons, and permits nurse aides to be tested orally on their competency evaluation if that is their preference. OBRA 1989 prohibits the imposition of charges for the training or competency evaluation programs. It also provides for temporary enhanced matching payments for costs incurred by States and facilities for nurse aide training and competency evaluation.

OBRA 1989 also included provisions to provide for the "grandmothering" of already-employed nurse aides. Those nurse aides who have received 60 hours of initial training and at least 15 hours of supervised practical nurse aide training or in-service education as of July 1, 1989, shall be considered to have completed a training and competency evaluation program. Those nurse aides who have completed a training course of at least 100 hours and have been found competent before July 1, 1989, shall be considered to have completed a training and competency evaluation program as well. Finally, States are authorized to waive the competency evaluation (but not the training) requirements with respect to persons who can demonstrate that he or she has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of enactment.

(4) Other OBRA 1987-Related Issues

The IoM report noted that one of the main factors affecting quality of care and quality of life in nursing homes is the number and quality of nursing staff. Greater numbers of nursing staff have been associated with improved resident outcomes. One of the primary differences between ICFs and SNFs is their nurse staffing requirements. Medicare (and Medicaid) SNFs must have licensed nurses on duty 24 hours per day, including the services of a registered nurse at least during the day shift, 7 days per week. Medicaid ICFs require only that a licensed nurse be on duty on the day shift 7 days per week. A licensed nurse is defined in both cases as registered nurse, a licensed practical or vocational nurse.

IoM also looked at the differences between SNFs and ICFs with regard to the type of residents that they served, and found that the distinctions between the two do not necessarily reflect differences in the residents that they care for. For these reasons, IoM recommended that the distinction between the two types of facilities be eliminated, and that participating facilities be subject to the same quality assurance criteria and procedures, with SNF minimum staffing requirements applied to all facilities. OBRA 1987 eliminates the distinction, and creates a new category referred to as a nursing facility (NF). As of October 1, 1990, all nursing facilities will have to meet a single set of requirements for participation in Medicaid. These are almost identical to Medicare's requirements.

For nurse staffing, OBRA 1987 requires that NFs meet Medicare's requirements. However, it provides for a broader waiver authority for NFs than for SNFs. NFs are permitted to waive either the registered nurse and the licensed nurse requirements; SNFs can waive only registered nurse requirements. Waivers will be granted by the States in strictly defined circumstances, and HCFA is in the process of drafting regulations implementing these requirements. Because registered nurses are in short supply nationwide, health care providers often must pay higher salaries in order to recruit and retain nursing personnel. These higher salary costs, as well as OBRA's mandate for increased nurse staffing, will likely lead to an increase in State's Medicaid costs. For this reason, there is some concern that States will have an incentive to grant waivers. The implementation of this provision of OBRA 1987 will likely be carefully monitored by nursing home consumer groups and State regulatory agencies.

(B) MEDICAID COVERAGE FOR IMPOVERISHED AGED

A particularly important concern over the past few years has been the issue of Medicaid spend-down for nursing home care. To become eligible for Medicaid coverage, persons must either be poor or spend-down their income to the level set by their State's Medicaid Program. While there is a great deal of variability among States' Medicaid programs and income eligibility levels, nursing home residents—and often their spouses—frequently face impoverishment before they become eligible for Medicaid coverage. According to the Department of Health and Human Services, about one-half of the persons receiving Medicaid coverage for their nursing home care became eligible after they entered the nursing home.

A recent study on the effects of nursing home use on Medicaid eligibility status found that the likelihood of being Medicaid eligible was 31 percent if a person spent time in a nursing home, as opposed to 7 percent for those who had not.[36] Medicaid eligibility is also closely related to length of stay in a nursing home. Although temporary or short stays in a nursing home do not increase one's risk of spending down to Medicaid eligibility, 41 percent of those persons studied who had long-term stays (i.e., at least 2 years) in nursing homes spent down to Medicaid eligibility.

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[36] Liu, Korbin, and Kenneth G. Manton. "The Effect of Nursing Home Use on Medicaid Eligibility." *The Gerontologist*, Vol. 29, No. 1, 1989, p. 63.

A provision in the Medicare Catastrophic Care Act (MCCA) addresses this issue of Medicaid spend-down. Although most of MCCA was repealed in November 1989, the so-called "spousal impoverishment" provisions were retained. Effective September 30, 1989, these provisions are intended to protect some of the income and assets of the spouse who remains at home when the institutionalized spouse is in the process of spending down in order to become Medicaid eligible.

Generally, when determining Medicaid eligibility, income (such as Social Security checks, pensions, and interest from investments) is attributed to the person whose name is on the instrument conveying the funds. In the case of Social Security, the amount attributed to each spouse is the individual's share of the couple's benefit. Therefore, if the couple's pension check is made out to the husband, all of that income would be considered his for the purpose of determining Medicaid eligibility. The attribution of resources such as certificates of deposit and savings accounts is done similarly. Because the recent generation of women whose husbands are at risk of needing nursing home care typically did not work outside the home, they likely have very little income or assets other than those in their husband's name.

Prior to the passage of MCCA, once an institutionalized spouse was determined Medicaid-eligibile, some of his monthly income was reserved for the use of his spouse. When combined with the community spouse's income (if one exists) it allows a maintenance needs level, which could not exceed the highest of the SSI, State supplementation, or "medically needy" standards in the State. According to a survey taken by the American Association of Retired Persons in March 1987, maintenance needs levels varied widely from State to State—from a high of $632 in Alaska to zero in Oklahoma. Thus, in a State which a maintenance needs level of $350, if the community spouse's monthly income were equal to $150, the contribution from the institutionalized spouse would be $200.

Under MCCA, States must allow the community-based spouse to keep at least $815 per month in income, or 122 percent of the Federal poverty level. This allowance would increase to 133 percent on July 1, 1991, and 150 percent on July 1, 1992. However, the maximum allowance will not exceed $1,500 per month. It also provides for a one-time determination of liquid assets, with half attributable to each spouse. The institutionalized person may transfer an amount equal to one-half, or $12,000, whichever, is higher, to the spouse, up to $60,000. For example, if the couple has assets worth $20,000, the institutionalized person may transfer $12,000 to the spouse. If they have assets worth $130,000, the institutionalized person may transfer $60,000 to the spouse, keeping $70,000 for himself or herself. If the spouse's share of their assets exceeds $60,000, the excess is attributed to the institutionalized persons. States have the option to increase these levels.

(C) PERSONAL NEEDS ALLOWANCE FOR MEDICAID NURSING HOME RESIDENTS

Nearly 800,000 Medicaid nursing home residents depend on their personal needs allowance (PNA) each month to cover a wide range of expenses not paid for by Medicaid. The current amount of the personal needs allowance is $30 per month—or $1 per day. With the passage of OBRA 1987, the PNA was increased from $25 to $30 per month, effective July 1, 1988. Prior to this, the PNA had not been increased—or even adjusted for inflation—since Congress first authorized payment in 1972. As a result, the $25 PNA was worth less than $10 in 1972 dollars. And while the $5 monthly increase in the PNA was certainly a victory, there is no provision to provide for a cost-of-living adjustment (COLA) in the PNA. Thus, all recipients of Social Security and SSI benefits have received COLA's to their benefits since 1974, except the frailest and most vulnerable—Medicaid nursing home residents.

For impoverished nursing home residents, the PNA represents the extent of their ability to purchase basic necessities like toothpaste and shampoo, eye glasses, clothing, laundry, newspapers, and phone calls. In addition to personal needs, many nursing home residents have substantial medical needs that are not covered by State Medicaid programs. Although the PNA is not intended to cover medical items, these residents may have to save their PNA's over many months to pay for these costs, such as hearing aids and dentures, preventing them from tending to personal needs.

If a nursing home resident enters a hospital, he must pay a daily fee to the nursing facility to reserve his bed there. Even though a resident who cannot pay this fee is likely to lose his place in the nursing home, 40 percent of State Medicaid plans will not cover the cost and guarantee the nursing home resident a bed to come back to. While the $30 monthly PNA represents an improvement over the $25 monthly PNA, many advocates of the Nation's nursing home residents believe it still is not adequate to meet the needs of most residents.

(D) LONG-TERM CARE OMBUDSMAN PROGRAM

The long-term care ombudsman program began as a demonstration project in the early 1970's as a part of the Federal response to serious quality-of-care concerns in the Nation's nursing homes. These demonstration ombudsman programs were charged with the responsibility to resolve the complaints made by or on behalf of nursing home residents, document problems in nursing homes, and test the effectiveness of the use of volunteers in responding to complaints. As a result of the success of the early programs, Congress incorporated the ombudsman program into the 1978 amendments to the Older Americans Act (OAA).

Under the OAA, each State is required to establish and operate a long-term care ombudsman program. These programs, under the direction of a full-time State ombudsman, have responsibilities built upon those outlined above. The programs are to: (1) Investigate and resolve complaints made by or on behalf of residents of long-term care facilities, (2) monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities, (3) provide information as appropriate to public agencies regarding the problems of residents of long-term care facilities, and (4) provide for training staff and volunteers and promote the development of citizen organizations to participate in the ombudsman program. The 1981 amendments to the OAA added the requirement that ombudsmen serve residents of board and care homes.

The primary role of long-term care ombudsmen is that of consumer advocate, and they are not limited to responding to complaints about the quality of care. Problems with public entitlements, guardianships, or any number of issues that a nursing home resident may encounter are within the jurisdiction of the ombudsman. A major objective of the ombudsman is to establish a regular presence in long-term care facilities, so that they can become well-acquainted with the residents, the employees, and the workings of the facility. This presence is important as it helps the ombudsman establish credibility and trust. Further, because about one-half of nursing home residents have no family, many may have only the ombudsman to speak on their behalf.

There are now about 600 local ombudsman programs throughout the Nation. According to the Administration on Aging (AoA), which is the Federal agency responsible for the OAA and the ombudsman program, the number of complaints handled by programs across the country almost tripled from 1982 to 1987, rising from 41,000 in 1982 to 110,000 in 1987. Of the 110,000 complaints received in 1987, AoA reports that about 65 percent were fully or partially resolved.

Funding devoted to the ombudsman program has grown in recent years. In fiscal year 1982, States reported that they spent $10.4 million on ombudsman activities, an amount which grew to over $20 million in fiscal year 1987. Staffing, both paid and volunteer, more than doubled from fiscal year 1982 to fiscal year 1987, from 4,171 to 9,854.

Despite the program's growth and effectiveness, Federal support, in terms of funding and statutory requirements has been inadequate. The Institute of Medicine's report on the quality of care in nursing homes noted that the ombudsman programs varied widely in their effectiveness, and stated the need to make improvements to the program in the future.

To address these concerns, the Older Americans Act Amendments of 1987 (P.L. 100-175) contained several provisions to strengthen and improve the long-term care ombudsman program. Among the provisions is a requirement that States provide access to facilities and to records, and immunity for good faith performance of duties. Further, they must provide adequate legal counsel and representation to ombudsmen if it is needed. Each State must also ensure that any willful interference with the official duties of ombudsmen is unlawful, and that retaliation or reprisals against facility residents and others who complain or cooperate with ombudsmen are unlawful.

The law also requires States to provide for the training of all personnel in the ombudsman program (including volunteers) in Federal, State, and local laws with respect to long-term care facilities in the State, in investigative techniques, and any other areas the State deems appropriate.

The 1987 legislation also required improved AoA reporting on the ombudsman program. It required that AoA submit to Congress, on an annual basis, information on complaints and conditions in long-term care facilities and recommendations on ways to improve conditions, among other things. In addition, the Commissioner of AoA was required to submit a report to Congress by December 31, 1989, on the findings and recommendations of a study of the impact of the long-term care ombudsman program on the care of residents of board and care facilities, and other adult care homes, as well as the effectiveness of recruiting, supervising, and retaining volunteers. As of this writing, these reports have not been submitted to Congress.

Congress, for the first time, established a separate authorization of funds for the ombudsman program in the 1987 OAA amendments, with an authorization of $20 million in fiscal year 1988, and such funds as may be necessary in fiscal years 1989–91. In 1989, Congress appropriated $988,000; in 1990, $974,000.

(E) NURSING HOME GUIDE

In December 1988, HCFA released a 75 volume publication entitled "Medicare/Medicaid Nursing Home Information." The publication contained a profile of each of the 15,000 nursing homes that participate in the Medicare and Medicaid programs derived from on-site inspections from surveyors in 50 State agencies. According to HCFA, "it reflects conditions in the nursing home at the time of its most recent survey and includes a summary of the characteristics of the residents in each home, their functional capacities and care needs." This publication has sparked a great deal of controversy among nursing home providers and consumer groups alike. While most congratulate HCFA on their attempt to provide better information to consumers, they claim that because the data used for the report are at least 1 year old (and in many cases, nearly two), and represent only a 1-day "snapshot" of the facility, the usefulness of this consumer guide is very limited. Consumer groups believe the guide presents nursing homes in a better light than is warranted, and provider groups claim the opposite is true. Both believe the report is inaccurate. Critics of the report believe providing reports on several inspections would give consumers a better sense of the facility's track record in complying with important quality concerns. Further, the guide only states whether or not a specific criterion was met, but does not specify the severity of the deficiency, or whether it is a one-time problem or an on-going concern. It also does not address the issue of inspector subjectivity, nor does it note that inspection and survey policies vary widely from State to State. Advocacy groups believe that consumers should be encouraged to examine the most recent inspection report at the home (homes are required by law to make these available), as well as contact the local or State ombudsman. HCFA plans to make the release of this report an annual event, although as of this writing, the 1989 version has yet to be released.

2. Home and Community-Based Care

There has been growing interest on the part of health care policymakers to expand the Federal role in providing home and community-based care for chronically ill elderly. Examples of this include expanding Medicaid's 2176 Home and Community Based Waiver Program, and board and care homes.

The need for this type of care is enormous. More than 4 million elderly Americans have limitations in activities of daily living, and roughly one-third of the Nation's nursing home residents do not need to be institutionalized. Finding ways to meet the needs of these people in home and community settings is a growing national concern. This section outlines current Federal issues relating to the Section 2176 program and the Older Americans Act as well as various proposals now before the Congress aimed at expanding Federal support to better meet the long-term care needs of the elderly in their homes.

(A) BOARD AND CARE HOMES

"Board and care" is a catch-all term used to describe a wide variety of nonmedical residential facilities, including group homes, foster homes, personal care homes, and rest homes. They may provide room, meals, assistance with activities such as bathing, dressing, and the taking of medication. A 1989 GAO report on board and care in six States [37] found that they are typically located in cities, have an average of 23 beds or less, and are privately operated. Residents of board and care homes frequently have physical limitations requiring some oversight, limited incomes (SSI recipients), and have often lived in an institution because of a mental disability. They are also unlikely to have friends or relatives visit them on a regular basis.

Board and care homes present unique quality problems. They provide care for poor, often mentally ill, disabled individuals who frequently have no place else to go. One of the major problems with operating board and care is that the providers, who are often poor themselves, do not receive enough money from their SSI residents to cover the cost of their care. In 1989, individual SSI recipients received $368 per month and couples received $553 per month. Although several States supplement SSI, it is nonetheless a very small amount of money with which to provide room, meals, supervision, etc. The task of providing adequate care is complicated further by the fact that many of the residents have illnesses or disabilities that demand more care than the board and care operator can afford or is trained to provide.

In 1976, in response to concern about problems in board and care homes, Congress enacted the Keys Amendment to the Social Security Act. It required States to certify to the Department of Health and Human Services (DHHS) that all facilities with a large number of SSI recipients as residents met appropriate standards. A 1987 survey of licensed facilities identified about 41,000 licensed homes, with about 563,000 beds serving the elderly, mentally ill, and mentally retarded. Of this amount, about 264,000 beds were identified as serving the elderly only. Data are not available on the number of unlicensed homes, although it is generally acknowledged that a greater number of homes are unlicensed than licensed.

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[37] U.S. General Accounting Office. *Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met.* GAO/HRD-89-50, February 1989.

The Keys Amendment does not mandate Federal regulation or licensure of board and care homes. There is only one enforcement sanction available to punish violators—the power to reduce the SSI checks of residents of homes not in compliance with State regulations, which acts as a disincentive for States to report deficiencies. Although all States now have health and safety provisions in law, Federal efforts to enforce board and care home standards have been hampered by lack of direct Federal funding of these facilities (SSI benefits are paid directly to board and care home residents or their representative payee, not the facility). This contrasts with nursing homes, where Federal Medicaid and Medicare programs pay the provider of care directly. Consequently, the Federal Government has been able to achieve stronger regulatory requirements for SNFs and ICFs.

Problems exist in licensed and unlicensed homes alike; in other words, licensing does not ensure quality care. Licensing requirements vary widely from State to State, and most inspections focus on the physical plant, with little or no emphasis on the residents and their quality of life. Because States do not aggregate the data gleaned from the inspection reports, the GAO report was limited in its ability to determine the magnitude and type of the violations or the kinds of homes in which the violations frequently occur. However, GAO did find that homes with predominately low-income residents (i.e., SSI recipients) had about twice as many violations on the average as homes with predominately private-pay residents.

The Department of Health and Human Services has played a circumscribed role in overseeing board and care facilities. While the Keys Amendment requires States to establish and enforce board and care standards, it only requires DHHS to receive the States' annual certifications concerning compliance. DHHS currently allocates only one-eighth of one person's time to checking that the States have sent in their certifications. Under this policy of very limited follow-up and oversight, a State can report its compliance with Keys even though it may have done little or nothing with respect to monitoring or licensing board and care homes.

In March 1989, the Senate Special Committee on Aging, the House Select Committee on Aging Subcommittee on Health and Long-Term Care, and the Subcommittee on Housing and Consumer Interests held a hearing to examine the problems as well as the attributes of the board and care system, and to explore ways to solve the problems while preserving these facilities' desirable qualities. The hearing found that many board and care homes provide grossly substandard care.

Because they offer independence and autonomy as well as some supervision, board and care homes can provide many elderly persons with an alternative to more costly institutional care. With the implementation of the OBRA 1987 regulations regarding screening and appropriate placement of mentally ill and mentally retarded nursing home patients, the role of board and care homes will likely become even more important. Legislation was introduced in 1989 to address some of the problems facing board and care residents and providers. These bills are H.R. 2219, the National Board and Care Reform Act of 1989, introduced by the late Representative Claude Pepper, and H.R. 3203, the Supplemental Security Income Community Living Amendments of 1989, introduced by Representative Fortney Stark. They will no doubt will lead to further discussions of the proper role of the board and care facility in our long-term care continuum, as well as the Federal and State role in oversight and regulation.

(B) MEDICAID 2176 WAIVERS PROGRAM

Prior to 1981, Federal regulations limited Medicaid home care services to the traditional acute care model. To counter the institutional bias of Federal long-term care spending, Congress in 1981 enacted new authority to waive certain Medicaid requirements to allow States to broaden coverage for range of community-based services and to receive Federal reimbursement for these services. Specifically, section 2176 of the Omnibus Budget Reconciliation Act of 1981 authorized the Secretary of the Department of Health and Human Services to approve "2176 waivers" for home and community-based services for individuals who, without such services, would require the level of care provided in a skilled nursing facility or intermediate care facility. Community-based services under the waiver include case management, homemaker/home health aide services, personal care services, adult day care services, habilitation services, respite care, and other community-based services. As of 1987, 46 States had established waiver programs, which now are serving roughly 60,000 elderly and disabled persons.

HCFA has expressed concern that the home and community-based waiver program may actually increase Federal expenditures for long-term care. While home and community-based care may be less costly on an individual recipient basis, aggregate Medicaid costs may increase if the program results in the provision of a new range of services to persons who would not otherwise use nursing homes/institutional care funded by Medicaid. Previous research and demonstration efforts in home and community-based care suggest that achieving program savings depends on how effectively waiver services are targeted. HCFA has argued that targeting the services to the population most at risk from entering an institution is quite difficult, if not impossible.

In an effort to restrict the program, HCFA in 1984 imposed a variety of impediments on States. There was, however, an enthusiastic response from States, patients, and their families for the waiver programs, as well as a need to develop alternatives to institutionalization. Therefore, Congress, as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, enacted various legislative proposals to ensure that the 2176 waiver option would continue to be available.

OBRA 1987 also includes provisions aimed at expanding the program. The act creates a new waiver authority under which the States can provide home and community-based services for the elderly alone. Under the waiver, the requirements for the program to be statewide, comparability, and income and resource rules applicable in the community are waived. Expenditures for skilled nursing facility services, intermediate care facility services, and home and community-based services for individuals 65 and older may not exceed a projected amount, which is determined by comparing the amount spent in the base year for such services increased by factors which take into account increases in the cost of goods and services, the over-75 population, and the intensity of services. It is anticipated that several States will establish more expansive home and community-care programs under this new waiver authority.

In 1989, Senator Rockefeller and Congressmen Wyden and Waxman introduced long-term care legislation which utilizes the 2176 waiver approach. This legislation, S. 1942 (originally introduced as S. 785, but reintroduced later in 1989 to incorporate some changes) and H.R. 1453, would permit States to amend their Medicaid programs to extend coverage for noninstitutional care services to low-income, functionally disabled persons over the age of 65. These services would include home health aides, nursing and personal care services, assistance with household chores, respite care, and adult day health services.

Although this legislation would provide similar types of services as under Medicaid's 2176 waivers, this approach has several advantages over the waivers. As discussed earlier, waivers have proved to be very difficult for States for a variety of reasons. Under H.R. 1453 and S. 1942, States are given the authority to choose to provide these services as an option under Medicaid, thus eliminating the need for waivers.

3. New Federal Initiatives

(A) LONG-TERM CARE FINANCING LEGISLATION IN THE 100TH CONGRESS

A number of bills have been introduced over the past few years to address the issue of comprehensive long-term care. Many were introduced in 1988, the second session of the 100th Congress; some were reintroduced in 1989, the first session of the 101st Congress in the same or a modified form. These bills address the issue from a variety of angles and perspectives, with different financing mechanisms and benefits packages, varying administrative approaches, etc. They are considered essentially "discussion pieces" in that each piece of legislation is the sponsor's ideal approach to providing comprehensive long-term care. Although no formal action was taken on these bills, when Congress and the Executive branch of the Federal Government finally hammer out an approach to long-term care, it will likely combine elements of each.

The following are brief synopses of the key initiatives that were introduced in 1988 and 1989, in reverse chronological order:

Elder Care Long-Term Assistance Act of 1989 (H.R. 3140 Waxman).—Amends Medicare to provide coverage of nursing facility and home and community-based services to chronically dependent persons. Payment for home and community services would be dependent upon an individual's degree of impairment and coverage would be limited to a specified number of hours per week. This bill would cover two-thirds of the costs of nursing home care after the first 60 days for 2 years. After that, the beneficiary could be responsible for 10 percent of the costs of care. It would be financed by removing the cap on wages subject to the medicare and Social Security payroll tax. (This bill was introduced in 1988 as H.R. 5320.)

Long-Term Care Act of 1989 (H.R. 2263, Pepper).—Establishes a long-term home care benefit under Medicare for the elderly and children. All chronically ill elderly, disabled, and children needing assistance with at least two ADLs would qualify for home care benefits. Payments for services are limited to a certain percentage of institutional care costs, depending on the eligibility category of the individual and degree of impairment. This would be financed by eliminating the cap on income that is subject to the Medicare payroll tax. No beneficiary cost-sharing is required. This bill is a slightly modified version of legislation Pepper introduced in the 100th Congress (H.R. 2762).

Lifecare Long-Term Care Protection Act (S. 2681, Kennedy, introduced in 1988).—Amends the Public Health Service Act to provide comprehensive coverage for nursing home and home and community-based care services for persons age 65 or older, Medicare disabled, or under age 19 who are functionally dependent in at least one or more ADLs. There are two parts to this approach—A (mandatory) and B (optional). Part A benefits would provide 6 months of nursing home care and community-based care with modest copayments. Part B would cover longer nursing home stays. Beneficiaries would have to enroll at age 45 (annual premiums of $120) or 65 (annual premiums of $300). Lifecare would cover 65 percent of the costs of nursing home care; the beneficiary (or insurance or Medicaid) would pay for the rest. It would be financed by raising the cap on wages subject to the Medicare payroll tax to $75,000.

Chronic-Care Medicare Long-Term Care Coverage Act of 1988 (H.R. 5393, Stark).—Amends Medicare to provide nursing home care to persons who are dependent in at least three ADLs and home and community-based care for persons dependent in at least two ADLs. Covers nursing home care under Part A after 3 months, with a 20-percent copayment. Under Part B, covers home health, homemaker, and personal care services, and adult day care, with a 20-percent copayment for home health and adult day care. It would be financed by an increase on the cap on wages subject to the Medicare payroll tax, as well as an increase in the tax, from 1.45 percent to 2.1 percent. It would also mandate the inclusion of all State and local employees in the Medicare payroll tax, increase the Medicare Part B premium, and certain estate and gift taxes. It also amends Medicaid to require coverage of long-term care benefit cost-sharing for certain low-income persons.

Long-Term Care Assistance Act of 1988 (S. 2305, Mitchell/H.R. 4763, Obey).—Amends Medicare to provide coverage of long-term home care services, home and community-based respite care, and long-term nursing home services for qualified beneficiaries who are functionally dependent in at least two ADLs. Beneficiaries would be eligible for coverage of nursing home care after a 2-year stay in an approved facility; there is a 30 percent cost-sharing requirement for nursing home benefits. There would be a $500 deductible for home health care, with 20 percent coinsurance; the respite care is subject to a $2,000/year cap, with 50-percent coinsurance. This legislation would be financed by a combination of beneficiary premium increases, copayments, the elimination of the cap on income subject to the Medicare payroll tax, and estate and gift taxes.

(B) LONG-TERM CARE AND THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

On July 1, 1988, President Reagan signed the "Medicare Catastrophic Coverage Act of 1988" into law (P.L. 100-360). Less than 18 months later, most of the law was repealed. (For a detailed analysis of the catastrophic legislation, please see the Health Chapter.) However, some portions of it were retained, among them the U.S. Bipartisan Commission on Comprehensive Health Care. Also known as the Pepper Commission, after the late Congressman Claude Pepper, who was instrumental in its formation, it was established to study and recommend to Congress ways to finance comprehensive long-term care, comprehensive health care services for the elderly and disabled, and comprehensive health care services for persons of all ages.

The 15 members of this commission are: Senators Baucus (D-MT), Durenberger (R-MN), Heinz (R-PA), Kennedy (D-MA), Pryor (D-AR), and Rockefeller (D-WV); Representatives Gradison (R-OH), Oakar (D-OH), Stark (D-CA), Stokes (D-OH), who replaced Congressman Pepper, Tauke (R-IA), and Waxman (D-CA); and Presidential appointees John Cogan, formerly of the Office of Management and Budget, James Davis, former president of the American Medical Association, and James Balog from the health insurance industry. Senator Rockefeller is the chairman of the Commission, a position held by Congressman Pepper until his death in June 1989.

The Pepper Commission's report is due on March 1, 1990. In a November policy-goal statement on long-term care, the Commission said that long-term care should be treated as an insurable event, in that it is an event whose risk can be spread through private and/or public coverage. It stated that coverage should be affordable to all Americans, and that it should support but not replace family support. The coverage should allow personal choice of care and setting, and assure quality care and provide for consumer protection. The Commission is committed to reaching agreement on how to raise the financing required to assure access, through public and/or private means, and to developing policies that control costs of current and future long-term care services. Finally, they are committed to promoting research on preventing or reducing disabilities that create a need for long-term care.

The Commission also must come up with recommendations on universal health insurance. In an outine of their plan to provide coverage to those who are employed but are under- or uninsured, the Commission said they will likely require employers to either provide their employees with health insurance covering hospital and physicians' services, and preventive care, or to pay a tax to help provide such coverage through a public fund.

The Pepper Commission is one of three Government groups focusing on comprehensive health care insurance. The Social Security Advisory Commission, formed at the behest of the White House, will issue its recommendations in July, and a task force appointed by the Secretary of DHHS will report in October.

C. PROGNOSIS

Although there was not a great deal of legislative activity in 1989 with regard to long-term care, it marked another year of incremental progress toward the provision of a broader range of quality long-term care services for the elderly. One of the most notable developments in 1989 with regard to health care for the elderly was the repeal of MCCA. Although momentum for repeal of the law gathered for a variety of reasons, a significant factor was the concern of many beneficiaries that MCCA did not provide long-term care.

Fortunately, some provisions of MCCA were salvaged, among them the U.S. Bipartisan Commission on Health and protection against spousal impoverishment, both of which are discussed earlier in the chapter. The recommendations of the Pepper Commission on the provision of comprehensive long-term care for the elderly and disabled, and health care coverage for the under- and uninsured populations, due to Congress by March 1, 1990, are eagerly anticipated. One of the biggest issues that the Pepper Commission must address is the relative roles that the public and private sectors will play in the financing of long-term care. This is an issue that shapes nearly every debate on long-term care, and regardless of the recommendations of the Pepper Commission, it will most likely continue to be a contentious and volatile one.

Although there is little consensus on many aspects of the long-term care, there is one area in which nearly everyone agrees: The enormous cost of providing comprehensive long-term care to the frail and disabled. In this time of huge Federal deficits, as well as many pressing social needs, such as homelessness, the drug crisis, and the burgeoning numbers of people in this country with no or very limited access to health care, finding the necessary funding is difficult at best. The Federal Government's interest and commitment to providing long-term care continues to grow, however, as is evidenced by not only the interest in the Pepper Commission, but also the Bush Administration's formation of two groups to examine the same issues.

Even though a comprehensive Federal long-term care program will likely not occur in the foreseeable future, increased emphasis will be placed on exploring alternatives to traditional long-term care. Congressional hearings and legislation designed to foster the development of creative alternatives to institutional care are anticipated. For example, Rockefeller's Medicaid Community Options bill (S. 1942) will likely be given serious consideration in 1990, and members of the Senate Aging Committee are expected to introduce legislation relating to board and care.

Elsewhere, a number of demonstration projects funded by the Office of Research and Demonstration at the Health Care Financing Administration are aimed at testing the effectiveness of community-based and in-home delivery systems for long-term care services. These projects include social health maintenance organizations, which provide for the integration of social and health care services, and respite care for impaired elderly. Similar projects are taking place at the State and local levels, as well as at colleges and universities.

OBRA 1987 nursing home reform and related issues will continue to be revisited and revised in 1990 and beyond. As various provisions of OBRA 1987 are implemented, unforeseen problems and issues will undoubtedly arise, leading to necessary adjustment and "fine-tuning" of the law. In 1989, a number of provisions amending OBRA 1987 were included in both the Senate Finance Committee's and the House Energy and Commerce's reconciliation bills that were reported out of the committees. Although the Energy and Commerce's bill passed the House unchanged, the Senate Finance Committee's was amended on the Senate floor, and nearly all of the provisions addressing nursing home reform were removed.

The final 1989 reconciliation bill (P.L. 101-239) included the Senate-passed version; in other words, very few provisions dealing with nursing home reform (the provisions that were included are discussed earlier in this chapter). Therefore, many of the original 1989 reconciliation provisions, many of which dealt with PASARR and nurse aide training, as well as other nursing home reform-related issues (e.g., the use of restraints) will likely be addressed and examined again in 1990, either through the reconciliation process or another legislative vehicle.

Chapter 9

HOUSING PROGRAMS

OVERVIEW

The housing and shelter needs of the elderly have been a concern in the area of aging social policy for a number of years. The need for housing for the elderly, particularly those with low and moderate incomes, continues to increase, to a large extent because of the Nation's steadily growing elderly population.

Current demographic projections indicate that the number of households headed by older persons continues to rise steadily. More than one-fifth of all U.S. households today—approximately 17 million—are headed by persons 65 years of age or older. Seven million are headed by persons over 75. A 1988 Harvard University study found that older renters pay a higher percentage of their incomes than younger renters, and older homeowners live in a higher percentage of substandard housing. From 1980 to 1995, the percentage of households headed by persons over 65 will rise by 33 percent and those headed by persons over 75 will increase 52 percent. In 1995, 21.4 million households will be headed by Americans over 65.

In addition, the rapidly growing need for special living arrangements and supportive services for older persons whose abilities to live independently have diminished is becoming increasingly recognized as a significant social policy concern. Increasing numbers of frail older persons—particularly those over 75 years of age—with mild to moderate impairments in their activities of daily living, are "aging in place" in federally assisted housing and other publicly supported housing units, and in private residences. Housing managers cite this as one of their most serious concerns. In the absence of supportive services, ranging from meals to various therapies, these individuals face the likelihood of having to leave their homes for other, typically more restrictive, living environments, including nursing homes.

Elderly renters comprise about one-third of all elderly households, and two-thirds of renters are single. This results in an acute problem for the elderly, because they pay a far larger share of their incomes for housing than homeowners. Recent data indicate, for example, that an elderly woman living alone spends nearly 50 percent of her income on housing. The problem is even worse in nonmetropolitan areas. Some 2.3 million elderly households spend more than 35 percent of their incomes on housing. According to a recent study by the Center on Budget and Policy Priorities and the Housing Assistance Council, two-thirds of poor elderly homeowners—66 percent—spent at least 30 percent of their income on housing, as did 75 percent of poor elderly renters.

The majority of the elderly have equity in their homes that could help in meeting their housing costs. Three out of every four elderly-headed households own their homes; 80 percent of them mortgage free. Some 60 percent of elderly poor households are owner occupied. For many, their home is their only asset. These factors have contributed to the growing interest in innovative housing arrangements, such as home equity conversion plans, and in strategies for the "overhoused" elderly homeowner to take advantage of maintenance-free housing through such alternatives as life-care communities.

Until 1981, the Federal Government had been substantially increasing its involvement in the production of housing for the low-income elderly. Since that time, Federal activity in the area of housing, particularly in the production of new units, has fallen off dramatically. There has been a change in Federal policy from an emphasis on long-term commitment in the form of construction of new housing and the rehabilitation and modernization of older housing, to a shorter-term commitment emphasizing the use of existing housing stock (for example, through the use of vouchers).

Housing programs at HUD have been on a substantial downward slope since fiscal year 1981. The largest decline has been in budget authority in the assisted housing category, down from $25 billion in fiscal year 1981 to $8.9 billion appropriated for fiscal year 1990—a reduction of over 80 percent when inflation is factored in. However, because actual spending for these programs is spread over a long period of time—20, 30, or even 40 years—cuts in budget authority are slow to result in reductions in outlays or actual spending. Thus, in spite of substantial reductions in budget authority, actual outlays on assisted housing programs increased from $5.72 billion in fiscal year 1981 to an estimated $12.3 billion in fiscal year 1989. The number of housholds receiving aid increased from about 3.2 million in 1981 to 4.5 million in 1989. These increases however, are attributable to funding commitments made prior to the Reagan and Bush Administrations, as well as to the shortening of contract terms. This results in the appropriation of requested budget authority being postponed to future years, therefore increasing the number of households presently assisted by a given amount of authority.

Despite congressional efforts to the contrary, Federal housing assistance meets only a small fraction of the housing needs of the low-income elderly. Yet low-income housing has taken deeper cuts than any other program providing aid to low-income people, and these cuts have come in the face of ever-increasing need.

In 1987, the Congress passed its first major housing legislation since 1980. The Housing and Community Development Act of 1987 (P.L. 100-424) reauthorized most housing and community development programs at a cost of $15 billion in fiscal year 1988 and $15.3 billion in fiscal year 1989. This figure included approximately $7.2 billion in fiscal year 1988 and $7.3 billion in fiscal year 1989 for low-income assisted housing. In 1989, Congress reauthorized these programs at a cost of $18.4 billion for fiscal year 1991, with this figure including $7.9 billion for low-income assisted housing.

The 1987 housing law made several important contributions concerning the elderly. These included; Making the Congregate Housing Services Program (CHSP), which helps to enable frail and disabled individuals to continue to live independently, permanent; establishing the home equity conversion demonstration, and taking steps to address the crucial issue of loss of existing housing stock through the prepayment of mortgages for low-income housing, including the Section 202 program.

At the beginning of 1989, housing advocates had hopes that the new administration signaled the end of nearly a decade of massive cutbacks, and that a new commitment to providing adequate, appropriate, affordable housing, within the constraints of the Federal budget, would begin. There were indications that the Bush Administration would make affordable housing a major part of its domestic spending agenda. The President's selection of former Congressman Jack Kemp as HUD Secretary suggested a leader who would not settle for overseeing the further demise of his department. Advocates expected that even if legislation was not enacted in 1989, the momentum toward reform would accelerate in the first session of the 101st Congress, thus setting the stage for the second session in 1990.

Unfortunately, the housing news in 1989 was dominated by the unfolding of major scandals involving the Federal Department of Housing and Urban Development (HUD) and the impact of the Nation's drug crisis in public and other low-income housing.

In 1989, as in previous years, Congress opposed the administration's housing policies. The budget proposal offered in early 1989, the beginning of the Bush Administration, for fiscal year 1990, was, in effect, the Reagan Administration's final budget proposal. For all practical purposes, it continued the Reagan Administration's assaults on funding for housing programs, including programs for the elderly. The administration's fiscal year 1990 budget proposed further cuts in the Section 202 program, from 10,000 units in fiscal year 1989 to 7,000 units in fiscal year 1990, and within this, to reduce the proportion of units dedicated to the elderly. The administration's budget also proposed to replace Section 202 direct loans with a new credit voucher program in which project sponsors would obtain financing from private sources for construction capital.

The administration also again proposed eliminating the CHSP, operated by HUD, on the grounds that the program did not achieve its primary goal—"to prevent premature institutionalization"—a conclusion strongly contested in a 1987 hearing and report from the Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging.

For fiscal year 1990, Congress rejected these administration proposals, but did not make further cuts in the number of units to be funded in the Section 202 program (8,500 units). The administration argued that new construction of federally assisted housing was unnecessary, particularly during this time of intense pressure to reduce the Federal deficit, and that the problem is, instead, the affordability of existing housing stock. As a result, Section 202 is virtually the only new construction being funded, albeit on a greatly reduced basis, resulting in very long waiting lists in many communities.

In 1989, Congress passed, and the President signed, H.R. 1, the "Department of Housing and Urban Development Reform Act of 1989" (Public Law 101-235), which addresses several key housing issues. Most notably, however, the title of this new law expresses clearly the housing theme in 1989—correcting many of the HUD-related abuses and problems that so graphically came to light in 1989.

The 1989 legislation also extends measures from the 1987 law to preserve existing HUD financed low-income housing stock, and makes permanent the prohibition on the prepayment of two key housing programs under the Farmers Home Administration (FmHA).

The other major source of housing-related news concerned the drug crisis, and the corresponding violence and other related crime, that seemed to be particularly rampant in public housing, at least in terms of media coverage. The reform spotlight turned to seeking ways to expedite the eviction from public housing of drug pushers, drug users, and those associated with them.

Senator Pryor chaired a hearing of the Senate Special Committee on Aging to examine a little recognized aspect of the drug crisis—its impact upon the elderly—including those who are tenants of public housing. This hearing graphically portrayed the plight of older tenants who are victimized by crime by drug-addicted family members and others; the fear that makes many tenants virtual prisoners in their homes; and the fact that growing numbers of older persons find themselves again assuming the child-rearing role as they take responsibility for their children's children or other young relatives, whose parents sell or use drugs.

Rapidly escalating housing costs have contributed to the growing need for Federal support. This problem is expected to continue as the number of older Americans increases and the cost of housing rises in relation to other living expenses. Housing costs for the elderly are being driven up by taxes, rising utility bills, higher home repair costs, and insurance, as well as rent hikes and condominium conversions. The result is a serious lack of affordable and safe shelter for a large number of older Americans, especially for the low-income.

Although the need for affordable housing and shelter assistance argues strongly for increased Federal efforts, resources, and leadership, fiscal concerns over the growing budget deficit, coupled with the legacy of the HUD scandals during the Reagan Administration, continue to make Federal housing assistance targets for budget reductions and major program changes.

Some argue that the scope of the scandals and the highly publicized drug-related problems are the consequence of Federal largesse and poor public policy. For many others, however, these problems are symptomatic of the Reagan Administration's disdain toward Federal assistance for housing, increased emphasis on the private sector, and the politicization of the award-giving and contracting processes.

For many, the 1989 scandals and crises are a watershed: Suggesting an end to the wholesale Federal retreat from the leadership and commitment that the Federal Government had shown toward housing for most of the past 50 years; 1989 would signal the resurgence, even if a slow one, of Federal responsibility and leadership, within the constraints of the Nation's budgetary problems.

A. FEDERAL HOUSING PROGRAMS

1. General Background

Beginning in the 1930's with the low-rent public housing program, the Federal role in housing for low- and moderate-income households has expanded significantly. In 1949, Congress adopted a national housing policy calling for a decent home and suitable living environment for every American family. The Federal Government has developed a variety of tools and programs in an effort to achieve this goal. One approach has been to provide housing directly through new construction programs and rental assistance payments aimed at providing adequate and affordable housing for those who could not otherwise afford it. A second and more costly approach has been to provide tax incentives for house construction and home ownership through deduction of mortgage interest and property tax payments from individual gross income and through a variety of tax provisions favoring real estate transactions.

Heightened concern with elderly related housing issues had its origins in 1950 when the first National Conference on Aging recommended greater Federal emphasis on the housing needs of older persons. It took almost 10 years, however, for legislation to be enacted that would eventually target the elderly as beneficiaries for such housing assistance.

Although low-income public housing created under the Housing Act of 1937 was not intended initially to provide special assistance for the elderly, it began to evolve into one of the prinicpal forms of Federal assistance for low-income older persons in the late 1950's. Prior to 1956, persons 65 years and older occupied only 10 percent of all low-income public housing units. Between 1956 and 1959, however, several legislative changes were made to encourage construction of units for the elderly. As a result, the percentage of public housing units occupied by the elderly increased to 19 percent in 1964 and to 45 percent in 1988. In addition, the first housing program specifically designed for the elderly, the Section 202 program, was enacted in 1959.

In the mid-1970's, Congress significantly expanded Federal housing assistance to the elderly. The Section 202 elderly housing program was reinstated after being phased out in the late 1960's, and the Section 8 housing assistance program was enacted. Although not specifically targeted to the elderly, Section 8 has become one of the two major sources of assisted housing units occupied by those 65 years of age and older. In 1988, Section 8 provided 983,000 units of assisted housing for the elderly. Public housing provides roughly 540,000 units for elderly families. There are now over 3,200 Section 202 projects nationwide, with over 230,000 occupied housing units. About 12,000 units are occupied by the physically or mentally handicapped.

(A) SECTION 202

The Section 202 program is the primary Federal financing vehicle for constructing subsidized rental housing for elderly and handicapped persons. Under the program, the Federal Government makes direct loans to private, nonprofit sponsors for use in developing Section 8 housing designed specifically to meet the needs of the low-income elderly and the handicapped.

The original Section 202 program operated from 1959 to 1969, when it was phased out in favor of other programs. During this 10-year period, the program provided construction financing and 50-year loans at 3 percent interest to nonprofit and limited-dividend sponsors of housing for low- and moderate-income elderly and handicapped persons. Approximately 45,000 units were constructed.

Under the revised Section 202 program authorized in 1974, loans to sponsors were made at a rate based on the average interest rate of all interest-bearing obligations of the United States forming a part of the public debt, plus an amount to cover administrative costs. The 202 loan rate was capped at 9.25 percent in 1983, in response to rising interest rates; it was lowered to 8.38 percent in fiscal year 1990.

The original Section 202 program was successful. Only one project was foreclosed during the 10-year period. The program served mostly middle-income rather than low-income elderly. Since the revised program is used in conjunction with the Section 8 program (HUD's major vehicle for the provision of housing to low-income households), it serves a wider range of elderly households.

Under the revised Section 202 program, funds are allocated on a geographic basis for metropolitan and non-metropolitan areas among the 10 HUD regions, taking into account the number of elderly households within each region, those households lacking some or all plumbing facilities, and those with incomes below regionally adjusted poverty levels.

(B) PUBLIC HOUSING

Conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing for the families of unemployed blue-collar workers, the Nation's Public Housing Program has burgeoned into a system that includes 1.4 million units housing more than 3.5 million people. In fiscal year 1989, Federal budget authority for public housing was $1.62 billion for operating subsidies, construction debts, and major repairs.

The Low-Rent Public Housing Program is the oldest of those Federal programs providing housing for the elderly. Approximately 541,000 units (45 percent) of the Nation's more than 1.2 million public housing units are occupied by older Americans. It is a federally financed program operated by locally established, nonprofit Public Housing Authorities (PHAs). Each PHA usually owns its own projects. By law, the PHAs can acquire or lease any real property appropriate for low-income housing. They also are authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects.

Until recently, Federal assistance to public housing projects has been in the form of annual contributions used to defray the PHA's debt. Beginning in fiscal year 1987, funding for development and modernization is provided through capital grants, rather than financing of long-term debt. Originally, funding of capital costs was the only form of Federal public housing assistance. It was assumed that tenants' rents would cover project operating costs for such items as management, maintenance, and utilities. Rents were originally set for each apartment regardless of income, then limited to 25 percent of net income, and are now 30 percent of net income. Tenant rents, however, have not kept pace with increased operating expenses.

Changes requiring greater targeting of benefits to the very low-income group (50 percent of area median rather than 80 percent) have also decreased rental revenues for the public housing authorities. As a result, beginning in 1969, Congress has provided additional assistance to the projects to cover these expenses. Operating subsidies totaled $1.5 billion in fiscal year 1989 and $1.79 billion in fiscal year 1990.

About one-half of the units in the Nation's 10,000 public housing projects are more than 20 years old, and many were built in the 1930's and 1940's. Much of the public housing stock is in need of major renovation. A congressionally mandated study by Abt Associates released by HUD in April 1988 (although initially released to the Senate HUD-Independent Agencies Subcommittee in April 1987), said that about $21.5 billion would be required to restore the housing to a safe and inhabitable condition. HUD has disagreed with that, stating that the cost would be $9.2 billion, less than one-half the amount estimated by Abt Associates. Among the funds HUD considers excessive in the Abt Associates' estimate are $5.7 billion for repairs it claims are not essential, $1.4 billion for energy conservation efforts, and money allocated for the 73,000 units (and possibly as many as 168,000) that will be demolished or sold. HUD's figure has been criticized by public housing supporters as grossly inadequate; a minimum of $18 billion was determined necessary by engineers and architects contributing to the Abt study.

Even its staunchest supporters admit that the program has been plagued by mismanagement in some cities and that problems are often aggravated by local political interference and patronage. It also is a system that has become home for many chronically unemployed and underemployed people who can ill-afford to pay significantly more in rents to offset the skyrocketing cost of operations and maintenance. And, over the past several years, a great deal of press attention has been devoted to drug trafficking and drug abuse in public housing.

About half of all the units in federally assisted housing were developed under and continue to be operated within the Public Housing Program. It has been by far the largest program for the production of housing for low-income families. In recent years, substantial dissatisfaction with the program has been voiced from several quarters, including Congress, about the condition of the projects and their management; from PHAs about their rising costs and the inadequate funding levels for operation and modernization; and from the OMB about ever-burgeoning outlays.

Another critical problem is increasingly being raised by the managers of public housing projects who are concerned about the lack of congregate services for their tenants who have "aged in place" and need supportive services to continue living independently. A 1986 study on aging in place in public housing projects found that the elderly in public housing are more likely than other elderly to live alone, and that 15 percent of the elderly households had at least one disabled member.[1] Another 70 percent of these households had annual incomes between $3,000 and $6,000; only about 25 percent had incomes over $6,000; with only 5 percent with incomes over $10,000. These households are heavily dependent on Social Security, and to a lesser extent, Supplemental Security Income (SSI). Only 10 to 15 percent had either wage or private pension income.

About 30 percent of PHAs will retain residents who have some supportive service needs; 10 percent require complete independence, and the rest will retain residents if they or others can arrange for the necessary services. About one-half of the elderly developments and 20 percent of the family developments reported operating under formal policies regarding the retention of residents. Of the 100 large PHAs surveyed (and a total of 204,800 elderly households), about 48 percent lived in units built for the elderly and handicapped, 15 percent lived in units built for the elderly but in mixed family/elderly developments, and 37 percent live in unmodified family units in family developments.

About 50 percent of the PHAs surveyed did not regularly collect any information about their elderly residents' functional levels, medical histories, or service use or needs. PHAs provide some services directly or through contracts with provider agencies in about half of all elderly developments and about 30 percent of all family developments. Only about 40 percent of the developments have onsite tenant services staff provided by the PHA; 20 percent of the PHAs report that no services or referrals are available except on an emergency basis in elderly developments. While a high proportion of developments have some services available that are used by some residents, there is evidence that these services may often only reach a few residents, leaving a large unmet need.

(C) SECTION 8

(1) Construction/Existing

The Section 8 program was created in 1974 to provide subsidized housing to families with incomes too low to obtain decent housing in the private market. Until 1983, HUD entered into assistance contracts with owners of existing housing or developers of new or substantially rehabilitated housing for a specified number of units to be leased by households meeting Federal eligibility standards. Authority to enter into new contracts for assistance to new or substantially rehabilitated units was eliminated in 1983. Payments made to owners and developers under assistance contracts are used to make up the difference between what the rental household can afford to pay for rent and what HUD has determined to be the fair market rent for the dwelling. As of the end of fiscal year 1989, there were 2.4 million units eligible for payment. Of those units, it was estimated by HUD that approximately 48 percent were occupied by older persons.

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[1] William L. Holshouser, Jr., *Aging in Place: The Demographic and Service Needs of Elders in Urban Public Housing* (Boston, MA: Citizens Housing and Planning Association), 1986, p. 185.

The concern over the Federal deficit has forced the Federal Government to reassess the cost effectiveness of many housing-related programs, including the new housing construction programs. Section 8 was not designed originally to provide any form of direct subsidy to project sponsors in meeting their costs of construction and financing, but was structured to stimulate construction by guaranteeing that low-income occupants would be subsidized through rental assistance programs, thereby assuring occupancy—and rental income—for the developed units.

Shortly after the start of the program, developers found they had difficulty in keeping their rents below those established by HUD's fair market rents, largely because of the high mortgage rates prevailing in the late 1970s. Consequently, effective rates were lowered for most projects, either by the Government National Mortgage Association's (Ginnie Mae) purchase of mortgages under its special function, or by financing from State housing financing agencies or from public housing agencies, both of which obtained funds from sale of tax-exempt bonds. Ginnie Mae exhausted its available funds, and it became evident in 1981 that increased rates in the tax-exempt market were threatening to halt assisted housing production. By the end of 1982, limited additional assistance had been provided to projects financed through State housing finance agencies by means of the finance adjustment factors which, in effect, raised permissible rents over the fair market rent level. The relatively high subsidy cost arising from both the high rent supplement required to cover construction costs and the additional indirect subsidy to lower interest rates caused increasing concern in the administration and Congress. Finally, in the Housing Act of 1983, the Section 8 new construction program was repealed except for that attached to the Section 202 program.

While the production component of the Section 8 program has been viewed as unsuccessful, the existing housing component of the Section 8 program generally has been alluded to as a successful form of assistance. Under the Section 8 existing housing program, HUD pays the difference between 30 percent of an assisted-housing tenant's income and the fair market rent standard for the jurisdiction. In fiscal year 1989, HUD paid approximately $9.7 billion in Section 8 housing assistance of all types to eligible families. This figure includes funding for the voucher program, which is expected to continue to be the administration's answer to subsidized housing in the future.

(2) Vouchers

As an alternative to traditional public housing and other Federal housing programs, the Reagan Administration strongly pushed for a system under which low-income families receive vouchers similar to food stamps. The Bush Administration is continuing this effort, although HUD Secretary Kemp has indicated that he does not want to be known as the "Secretary of Vouchers." Vouchers are intended to enable a family to rent housing in the private market, assisted by a Federal payment transmitted through a local public housing agency to a landlord. The voucher subsidizes the difference between 30 percent of the family's income and the fair market rent of a suitable sized unit, although the actual rent may be more or less than the fair market rent.

The Housing Act of 1983 continued existing Section 8 certificates, but also established a Section 8(o) voucher demonstration program. Use of the 15,000 vouchers authorized by the act was limited primarily to HUD's new Rental Rehabilitation and Development Program. However, 5,000 units were allocated to a free-standing program to provide an opportunity to compare the operation of the voucher program with the Section 8 existing certificate program.

Under the voucher system, also referred to originally as the modified Section 8 existing housing certificate, HUD's contribution also is based on the difference between an established rent payment standard for each market and 30 percent of a new tenant's income. Like fair market rents, the rent standard is set at the 45th percentile of the distribution of rents of standard quality in newly occupied units, and tenant eligibility is based on an income standard of 50 percent of area median income.

The tenant, however, likely will pay more or less than 30 percent of his or her income for rent. HUD's contribution still is based on a 30-percent-of-income contribution, but the rent standard is not necessarily the actual, or maximum, rent. Rather, the rent received by the landlord is based on whatever is negotiated between the tenant and landlord, as in the private market, Thus, if a tenant finds a unit that is cheaper than HUD's rent standard, that tenant would be able to keep some of the subsidy for other uses. Conversely, if a tenant rents a unit that is more costly than the rent standard HUD uses, the tenant would have to contribute more than 30 percent of income to make up the rent payment. Another difference between the two programs is the duration of the assistance contract which is limited to 5 years under the voucher program compared to the 15-year duration of the Section 8 existing housing contracts. The HUD appropriations act for 1985 provided $500,000 for HUD's research budget to evaluate vouchers versus 5- and 15-year Section 8 contracts. Abt Associates, contractors for this study, found that elderly had greater success with vouchers than with the Section 8 certificates as they use the vouchers to "age in place."

(3) Rental Rehabilitation and Development

New rental rehabilitation and production programs were enacted under Title I of the Housing and Urban-Rural Recovery Act of 1983 (P.L. 98-181). The programs authorize Federal commitments of just 5 years (much shorter than the 15- or 20-year commitments under Section 8), and have geater requirements for local public and private sector investments in the projects, stricter limits on Federal per-unit costs, and geater demonstration of rental housing need by local authorities.

The Rental Rehabilitation program is designed to increase the supply of low-income rental housing in areas experiencing a shortage of suitable units. Rehabilitation subsidies are provided through a one-time front-end mechanism such as a grant, deferred payment loan, or below market interest loan. It provides the difference in what the owner of rental property can afford to borrow from a private lending institution and what it actually takes to rehabilitate the property. No distinction is made between single- and multifamily dwellings, as long as they are primarily rental and residential in nature. Rental subsidies in the form of housing certificates or vouchers are then used to permit low-income tenants to live in the renovated housing.

According to HUD, the number of completed units has increased dramatically in the past 2 years. As of September 1989, the total commitments for 1989 were 8,801 projects containing 35,983 units. During that same year, 9,519 projects (37,810 units) were completed. Due to the fact that approximately 28 percent of the 1988 committed projects were not finished until 1989, the number of completed projects for 1989 is greater than the total number of committed projects. Cumulatively, there have been 35,322 projects committed (165,917 units) and, of these, 28,665 projects have been completed (117,993 units). Elderly tenants account for approximately 11 percent of the occupied units of these buildings.

In recent years, HUD has demonstrated a tendency to disassociate Section 8 vouchers from the rental rehabilitation program. This appears to go against the original design of the program. Not only was the program enacted to ensure that the housing supply in urban areas was adequate and livable, but also that those tenants displaced either physically (through the actual rehabilitation process) or economically (through higher rents) would be provided with other housing options. The Housing and Community Development Act states that those tenants physically displaced must be provided with rental assistance. Those who are economically displaced may or may not receive assistance, which will be left to the discretion of their local PHA.

The fiscal year 1989 appropriation for the program was $150 million. The fiscal year 1990 appropriation for rental rehabilitation is $128 million; with $20 million in recaptures from fiscal year 1989, tht total will be $148 million.

(D) THE FARMERS HOME ADMINISTRATION

The Housing Act of 1949 authorized the Farmers Home Administration (FmHA), administered by the Department of Agriculture, to make loans and grants to farm owners to construct or repair farm dwellings and other buildings. Amendments to the Act made the programs available to rural residents, in general, to purchase or repair homes and for other purposes. The rural housing programs of FmHA are generally referred to by the section number under which they were authorized in the Housing Act of 1949 and its subsequent amendments.

Section 502 loans enable low-income rural residents to purchase or repair new or existing single-family housing. Borrowers may receive interest credit to reduce the interest rate to as low as 1 percent. The loans are repayable over a 33-year period. The loan term may be 38 years for borrowers with income below 60 percent of the area median. The borrowers must be unable to obtain credit elsewhere on reasonable terms.

Section 504 loans are made to rural homeowners who could not afford a section 502 loan but need funds to make the dwellings safe and sanitary or to remove health hazards. Very-low-income elderly homeowners may qualify for grants or some combination of loans and grants.

With Section 514 loans, farmers or organizations may obtain 33-year loans to provide "modest" living quarters and related facilities for domestic farm laborers. Qualified nonprofit organizations, Indian tribes, and public bodies may obtain Section 516 grants for up to 90 percent of the development cost of such housing.

Under Section 515, by far the largest and most important FmHA program serving the elderly, developers may obtain 50-year, 1 percent loans to build rental housing for rural residents or congregate housing for the elderly and handicapped. Except for public bodies, all borrowers must demonstrate that financial assistance from other sources will not enable the borrower to provide the housing at terms that are affordable to the target population.

Section 521 provides for rental assistance payments to borrowers to make up the difference between the tenants' payments and the FmHA-approved rents for the housing (financed under Section 514 or Section 515). Borrowers must agree to operate the property on a limited profit or nonprofit basis.

Section 533 preservation grants authorized FmHA to make grants to organizations for rehabilitating rural single family homes, rental properties, and cooperative housing.

2. ISSUES AND LEGISLATION

(A) LIMITING THE FEDERAL ROLE

Since its inception, housing policy in America has focused almost exclusively on the provision of standard units of low and moderate-income housing for eligible individuals and families. This approach has been inadequate in that the Federal Government has been unwilling to treat housing assistance as an entitlement. As a result, many eligible households simply cannot find the assistance they need. Data indicates that the 4.5 million assisted units available at the end of fiscal year 1985 are enough for, at best, 25 percent of those eligible for assistance. Further, while there were 16 million elderly households in 1980, this number is projected to increase to 23 million in the year 2000. This means that the elderly will need 7 million more units in 2000 than they had in 1980—assuming that all elderly households in 1980 were decently housed and that the present housing stock will be maintained.

According to a 1986 report of the National Low Income Housing Coalition, Federal housing efforts have fallen far short of meeting elderly housing needs. In 1984, there were 1.1 million elderly renter households with incomes below the proverty level. Only 444,000, or not quite 40 percent, of these households lived in subsidized housing. The remainder lived either in substandard housing or paid more for housing than they could afford, or both. The Coalition estiamtes that, at the minimum, almost 700,000 poor elderly need housing assistance. In addition, there are 1.5 million elderly homeowners with incomes below the proverty level.

A 1988 study by the National Low Income Housing Preservation Commission found that as a result of expiring Federal housing support programs and the effects of the 1986 tax reform act, defaults and prepayments could remove as much as 81 percent of the stock from the inventory of low-income housing. If no action is taken, 523,000 of the 645,000 units subsidized under Sections 221(d)(3) and 236 of the 1961 and 1968 Housing Acts (which was the focus of the Commisison's study) will be lost to low-income households at the end of 15 years. Owners of 280,000 units will default on their mortgages, allowing the properties to revert to the Federal Government for disposition. Owners of another 243,000 units will likely convert them to market-rent apartments, sell them as condominiums, or use them for other higher income purposes. Only 122,000 would remain for use as low-income housing. According to the report, two groups—the elderly and large families—are most likely to be hurt by prepayments and defaults as they are least able to cope with displacement or find comparable replacement housing. It will also hurt those with the lowest incomes—70 percent of the tenants of the threatened housing stock have incomes below 50 percent of the midian for their area.

A report released in February 1988 by the National Housing Preservation Task Force states that the major threat to the inventory of low- and moderate-income housing comes not from prepayment of mortgages, but rather from expiring Section 8 subsidy contacts. According to the report, over 700,000 units could be lost by 1995; if owners choose to opt out of their contracts early, the loss could approach 1 million units by 1995 and 1.4 million by 2000.

Although the present need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit continue to make these programs targets for budget savings. The net effect of these fiscal constrainsts resulted in a policy shift by the Reagan administration toward other approaches for meeting the housing needs of older persons. President Reagan was successful in shifting the mix of additional units assisted by HUD from the more expensive new construction and substantial rehabilitation types to existing units leased in the open market. Under that administration, the primary emphasis with regard to public housing for the elderly became preservation, maintenance, and rehabilitation of the existing housing stock. Although housing programs have had greater visibility under President Bush and HUD Secreary Jack Kemp, it is unlikely that housing will become a top priority of the current Administration.

The Reagan and Bush Administrations' emphasis on using existing housing is based not only on cost considerations but also on the belief that there is an adequate supply of low- and moderate-income rental housing in most areas of the country. They have contended that the need for housing assistance in America can be met most efficiently by providing Section 8 certificates or, preferably, vouchers to eligible families for existing rental housing.

Nonetheless, a large percentage of new cosntruction of housing over the past 10 years has been for the elderly. The relative lack of management problems and local opposition to family units make elderly projects more popular. Yet, even with this preference for the construction of units for the elderly, in many communities there is a long waiting list for admission to projects serving the elderly. Such lists can be expected to increase as the demand for elderly rental housing continues to increase in many parts of the Nation.

The administration's budget request for HUD-assisted housing for fiscal year 1990 was $7.4 billion, which included 109,000 incremental housing units, largely assisted with vouchers. There would be no new construction of assisted housing with the exception of 7,000 Section 202 units for the elderly and handicapped. The HUD Appropriations Act (P.L. 101-144) provided $8.9 billion to support assisted housing in fiscal year 1990. This funding will provide 82,000 additional units; 57,000 of these involve Section 8 vouchers or certificates.

In 1987, the first major housing bill in 7 years was signed by the President. This legislation, the Housing and Commmunity Development Act of 1987 (HCDA), enacted as Public Law 100-242, authorized most housing and community development programs for 2 years, at a cost of approximately $15.3 billion in fiscal year 1989, and $18.4 billion in fiscal year 1990. Housing programs were authorized for another year, through fiscal year 1990, by the enactment of H.R. 1, the "Department of Housing and Urban Development Reform Act of 1989," which was signed by the President on December 15, 1989, as Public Law 101-235.

While the 1989 law reauthorized housing programs for another year, its main thrust is to address the very serious management problems that evidently plagued HUD and other key Federal housing entities such as the Federal Housing Administration (FHA) for most of the past decade, as evidenced by the HUD-related scandals that emerged throughout 1989. Many of these reforms were in addition to the administrative actions that Secretary Kemp had taken during the year to address the problems that he had inherited, such as ending or suspending certain housing programs. Specific provisions ranged from: Establishing civil money penalties for violations of law; limiting HUD's discretion in the awarding of funds; establishing key positions to provide greater accountability over funds, such as a HUD Chief Financial Officer, and a (FHA) Comptroller; expediting the rule-making process; reforming certain programs such as the moderate rehabilitation program.

The 1989 Act also addressed the serious mortgage prepayment problem (see discussion elsewhere in this chapter) by extending until September 30, 1990, the emergency interim measures estrablished for HUD programs in the Housing and Community Development Act (HCDA) of 1987, and by permanently prohibiting prepayment in the FmHA Section 515 program. In addition, the 1989 law establishes a National Commission on Severely Distressed Public Housing and a National Commission on Native American, Alaska Native, and Native Hawaiian Housing.

(1) Section 202

The Section 202 program is the most visible elderly housing program. Overall, it is considered one of the most successful of all assisted housing programs. Moreover, it now accounts for virtually all that remains of federally assisted new construction for low-income Americans. While the Section 202 program has generally produced quality and financially viable housing projects for the elderly and the handicapped, it has also experienced some political controversy and, over the past decade, has had its problems and criticisms. These issues stem from several problems, including the program's high production costs, the tendency, at least of the original program, to serve primarily moderate and middle-income elderly, and the draw that the program makes annually on the Federal budget because of its use of direct loans from the Federal Government at reduced interest rates.

There are an average of six Section 202 units for every 1,000 elderly persons in the country. According to a December 1989 report by the Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging, a national 1988 survey showed an average turnover rate of only 13.4 percent annually. Turnover rates are even lower in the oldest facilities, with the transfer to a nursing home or death being the more likely reason for the turnover in these facilities.

As a result, there are lengthy waiting lists for Section 202 housing across the Nation. According to this same Housing Subcommittee report, only 8.2 percent of Section 202 facilities had no waiting list, and 3.2 percent of facilities in the Northeast reported they had no waiting list. Furthermore, the survey found that in 1987 facilities in cities of more than 1 million reported that for every vacant unit there were 11 applicants. This ratio jumped to 28.5 applicants for every vacancy in those facilities most recently built. It is important to note that waiting lists represent only those who chose to apply—not those who were discouraged by the prospect of a long wait and therefore chose not to apply.

Indeed, the housing needs of several million elderly—housing that is affordable, safe, accessible, and suitable in terms of neighborhood amenities and services—have gone unaddressed. Program cuts have come not only at a time of current high demand, but also at a time when demand is expected to increase. The enormous projected growth of the elderly population suggests the prospect of rapidly increasing shelter and service needs that the Nation has just begun to recognize.

In 1985, $600 million was appropriated for 12,000 units of Section 202 housing. As part of the President's spending freeze to reduce the Federal deficit, his fiscal year 1986 budget proposed a 2-year moratorium on new assisted housing production. Congress, however, did not agree with this proposal and $631 million was appropriated in fiscal year 1986 for the construction of 12,000 Section 202 housing units. For fiscal year 1987, $593 million was appropriated to fund the construction of approximately 12,000 units of housing for the elderly and handicapped.

The 1987 HCDA authorizes $622 million in fiscal year 1988 and $630 million in fiscal year 1989 in loans under the Section 202 program. However, the fiscal year 1988 direct loan limitation for Section 202 was $565.8 million, which was intended to provide funding for the construction of approximately 10,990 new units. Further, the appropriations bill required that 25 percent of the loan authority under Section 202 must be used only for handicapped project loans, which represented an increase in the number of units built for the handicapped—and a decrease in the number of units built for the elderly. Ultimately, 25 percent of the funding for Section 202 in fiscal year 1989 went to handicapped housing. The fiscal year 1990 direct loan limitation for Section 202 housing in $472.6 million, with 25 percent targeted for exclusive use by the handicapped (2,375 units, with 950 targeted for the deinstitutionalized mentally ill). This will fund construction of approximately 8,500 new units for the elderly and disabled.

Because Section 202 is one of the only Federal housing programs where new construction is taking place, it is likely that the program will continue to be the focus of attention from the various groups in need of housing. While most housing advocates agree that the elderly are but one of several segments of the population in need of safe and affordable housing, many feel it is tragic that those concerned about the housing needs of a particular segment of our population find themselves competing for scarce housing dollars.

Section 202 has been the target of numerous regulatory and administrative changes over the past decade, which were intended to make the program more cost-effective and to target assistance to the neediest of elderly and handicapped persons. These recent changes in program direction, coupled with the continuing policy issues mentioned earlier, have been, and will continue to be, the focus of debate in the years to come.

Cost containment requirements in the Section 202 program appear to have been working to change the program from providing housing with supportive services for the elderly to one of providing only minimal housing. Recent changes made to the Section 202 program to increase its cost-effectiveness and to allow more units to be built with the same amount of money include: Requiring Section 8 recipients in Section 202 projects to pay 30 percent—instead of 25 percent—of the household's adjusted income for rent; requiring that at least 25 percent of the units in a project be efficiencies (i.e., one room); and limits on sponsors on the size of the units, congregate space, and number of amenities. The establishment of maximum sizes for apartment units and community spaces removes much of the flexibility in design required to meet the changing needs of an aging population. To serve a more frail, elderly population, sponsors need a facility designed with smaller units and more congregate space. Policies of rigidity rather than flexibility may virtually eliminate the possibility of developing a proper facility for an increasingly frail population.

A 1986 GAO study of cost containment in the Section 202 program revealed that although cost containment efforts had been successful in lowering costs, they were having other adverse effects. Analysis of contruction cost data revealed that cost containment projects averaged 16 percent less than the average cost of units in projects built before cost containment. GAO concluded that without cost containment, Section 202 projects for fiscal year 1985 would have cost an additional $100 million. However, there were problems related to the cost containment efforts. Units were, on average, 11 percent smaller, included more efficiencies, which are less desirable than one-bedroom apartments, and fewer amenities for the residents.

At the close of 1989, the Secretary of HUD, in a report to Congress, responded to congressional pressure concerning cost containment efforts in the Section 202 program by indicating that HUD is currently reviewing the cost containment policies and guidelines, including requirements governing efficiency units, common areas, and elevators. HUD indicated that the review would be completed in time to make changes effective for sponsors seeking fiscal year 1990 fund reservations.

One of the most significant issues raised by the study relates to the use of fair market rents (FMR) which HUD establishes for an area on the basis of rents tenants are willing to pay for housing. HUD has established 363 FMR areas. GAO found that FMR's for a particular area play an important role in the ability of the project sponsors to provide quality housing for the elderly. Project rents cannot exceed 120 percent of the FMR established by HUD for an area. The income from project rents is used to pay for a project's operating and maintenance expenses and to amortize project financing costs (principle and interest). Consequently, by controlling the rental income which can be collected, FMR's serve to limit the mortgage financing or loans and, in turn, the projects' construction costs. HUD's policy uses rents to determine costs, rather than vice versa. This makes it difficult for Section 202 sponsors in areas with relatively low FMR's to provide housing consistent with higher FMR areas.

A 1987 study by Conroy and McIver supports these findings. It cites the arbitrary nature of FMRs, stating that "Fair Market Rents are neither fair nor market. How can the . . . rent be $376 in Augusta, Georgia and $502 in North Augusta, South Carolina when these two cities comprise one community . . . ?" [2]

FMR's preclude the construction of some projects built in one area from being built in another because their cost would be too high. Again, Conroy and McIver corroborated these findings. Conroy and McIver compared the average construction costs for a typical Section 202 building in each FMR area with the construction costs "allowed" or supported by the FMR in each area (which are the costs upon which HUD bases its approval of projects). They found that in 66 of the 363 FMR areas, it would be almost impossible to build the typical project without significantly compromising underwriting criteria or without a significant contribution from the project sponsor or the locality. (Small sponsoring organizations are often unable to make contributions; if a locality is willing to make it, it often comes out of Community Development Block Grant (CDBG) funds.) Further, they found that there would be severe cost problems (shortfalls between $250,000 and $500,000) in 144 other areas.

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[2] Letter from Diana L. McIver of Conroy & McIver to Thomas Demery, Assistant Secretary for Housing, HUD, Washington, DC, April 27, 1987.

A serious problem that has emerged over the past several years that led to congressional action in 1989 is the extraordinary backlog of approved (for financing and construction) Section 202 projects that have not yet been constructed. These approved projects are blocked in what is known as the construction "pipeline." The pipeline blockage has reached extraordinary proportions and threatens the financial viability of previously approved projects. Some suggest that the number of units in the pipeline may be as high as 60,000 units; HUD, in a congressionally mandated report, acknowledged that the "current Section 202 pipeline represents about 26,000 units." Even at the lower figure of 26,000 units, this amount takes on particular significance when considering the fact that the fiscal year 90 appropriation is for 8,500 units, in fiscal year 89 it was for 9,500 units, and for fiscal year 88 the appropriations were for 10,990 units; the pipeline, at minimum, is equal to 90 percent of the total number of units approved by Congress for the past 3 fiscal years.

The pipeline problem reflects, at least in large part, the serious problems that have developed with the FMRs. The House Appropriations Committee specifically directed HUD to submit a report to Congress by October 1, 1989 "outlining specific remedies to move these [units in the pipeline] and future Section 202 elderly/handicapped units to production in a timely manner. Specifically, the committee urges the Department [HUD] to review the method by which fair market rents are determined for Section 202 projects." HUD Secretary Kemp, in his response to Congress, acknowledged the role that FMRs play while outlining immediate steps that HUD was taking to reduce the pipeline as well as future actions on the problem, stating "I have directed my staff to review the whole procedure for establishing the new construction Fair Market Rents." The Secretary also stated his "hope that the Department can find a much more efficient and timely way to establish reasonable rent limits for the Section 202 elderly program, one that . . . avoids many of the problems experienced in recent years."

Critics of the HUD construction requirements for cutting costs say that they are so stringent that some of the new buildings are too poorly constructed to last the 40-year term of the mortgages. Therefore, amenities like meeting halls and recreational areas, which draw the elderly into a community, are being sacrificed.

There is general support for cost containment in that maximizing the number of units built enables the program to serve more people. However, because many of the cost containment policies result in either inadequate housing or discourage the development of new housing, critics believe they are misguided at best. Many housing advocacy groups support reevaluation and possible elimination of many of these policies, FMR's among them. In conclusion, the findings of GAO and Conroy and McIver strongly suggest that there are cost containment issues that must be resolved to provide the most elderly with suitable housing given the limited funds available for the Section 202 program. 1989 ended on a positive note for Section 202 with the Secretary acknowledging these problems and indicating that HUD would address them.

(2) Vouchers

Advocates of the voucher program argue that, like the Section 8 certificate programs, the voucher system would avoid the segregation and warehousing of the poor in housing projects and would allow low-income families to choose where they live—all at less cost than new construction programs. They argue this provides an incentive to families to search for lower cost, though standard quality, rental units, and also permits those who value housing highly to rent better quality or larger units by paying more of their income for rent. Moreover, since the contract is for 5 years rather than 15, less budget authority need be appropriated in any 1 year for the same number of assisted families. Recipients of Section 8 certificates do not have this option. However, the 1989 HUD appropriations bill reduced the contract term for Section 8 certificates to 5 years, in an effort to place the vouchers and existing certificate units on the same basis.

Shifting to voucher assistance present potential problems for the elderly in need of housing assistance. Although Abt Associates report that the elderly use vouchers more successfully than other age groups as they use them to "age in place," it is important that vouchers not be looked to as a replacement for new construction of housing for the elderly that is built to accomodate their special needs, such as accommodation for wheelchairs and grab rails in bathrooms, in the private market.

The voucher system has been met with skepticism by Congress and many housing advocates. Critics of the program point to a shortage of decent low-cost housing in the largest cities. They question whether vouchers will provide real help to those most in need or simply encourage private landlords to increase rents because they know tenants have additional funds available. Critics raise the point that since the vouchers are only authorized for 5 years, they do not represent a commitment to providing housing for the poor. They believe the budget savings are illusory, since the need will continue, and, presumably, additional funds will be appropriated to continue assistance at the end of the 5-year period.

There is also concern that vouchers are costing more than Section 8 certificates, which has been exacerbated by HUD's failure to adjust FMR's to reflect changing market conditions. According to the Senate Appropriations Committee, there is considerable evidence that in depressed housing markets such as Houston, FMR's have remained artificially high, giving voucher holders an economic windfall since their housing subsidies are based on the FMR. Conversely, in New York City, voucher holders may have to pay 50 percent or more of their income for rent because the voucher payments they receive are based on an unrealistically low rent. The committee believes HUD should explore methods of setting the FMR to more accurately reflect shifts in local housing marekts as a means of reducing the inequities arising between voucher holders and certificate holders in various parts of the country.

In fiscal year 1988, $1.167 billion was appropriated to fund 49,000 additional housing vouchers; the fiscal year 1989 appropriation of $1.35 billion provided for 48,500 additional housing vouchers. In fiscal year 1990, $2.75 billion has been appropriated to fund 98,900 voucher units; of that amount, 56,800 are incremental units, 42,100 for Section 8 "opt-outs/prepayments."

As 1989 ended, the Bush Administration was expected to propose a demonstration project that would involve the use of vouchers to help the frail elderly to pay the costs of supportive services that they need.

(3) Income Eligibility Requirements

The Omnibus Budget Reconciliation Act of 1981 also reduced the income eligibility limit for almost all applications to 50 percent of the median income in the local area. The previous limit was 80 percent. Only 10 percent of those admitted to units available before the Act and 5 percent of those who rented units becoming available after the Act could have incomes between 50 percent and 60 percent of median.

The percentage of those with incomes from 50 percent to 80 percent of median admitted to previously available units was increased from 10 to 25 in 1983, but 5 percent was kept for those becoming available after the Act became law. It was assumed that this provision would better match low-income housing programs with those who are most in need of assistance. This change was to apply to new tenants only. The continued eligibility of current tenants with incomes above 50 percent of median was unchallenged. HUD regulations implementing these changes in the law were promulgated in 1984.

There have been complaints that HUD has implemented the 5 percent limitation in such a way as to prevent renting to lower income (from 50 to 80 percent of median) households in almost all projects. Efforts have been made in the last few years to liberalize enforcement of the provision. The Housing and Community Development Act of 1987 forbids HUD from establishing procedures with totally prohibit admission of lower income families, and instructs it to establish different percentage limitations in the various programs in such a way that the total when aggregated over the entire spectrum of assisted housing programs will meet the percentage limit in the Act.

As the funding for Section 202 housing becomes increasingly difficult to obtain, there may be continued efforts by some to focus on the very poorest. This may be difficult to do because the program has historically served a more middle- and low-income population.

(4) Tax Reform

A large and important part of Federal housing assistance is provided through the tax system—close to $50 billion for fiscal year 1989, mostly for middle and upper income homeowners. The principal tax provisions encouraging home ownership are the mortgage interest and property tax deductions. The latter is probably more important to elderly owners since many have fully paid their mortgages.

While the tax deduction for property taxes remains fully deductible, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) placed a limit on the amount of mortgage interest that could be deducted. OBRA 1987 limits the total mortgage interest on a principal and second residence that can be deducted on debt of up to $1 million incurred after October 13, 1987. This, of course, is likely to be of little concern to most home owners. However, since for most home owners, the amount of deductible mortgage debt is equal to the current amount of their mortgage, and under the new law this is reduced as the mortgage is paid down, some care should be made not to prepay the mortgage with funds that they may need in the near future. This concern is considerably reduced for most owners by another OBRA 1987 provision that allows interest to be deducted on up to $100,000 of home equity loans. Of particular importance to the elderly, the one-time exclusion that allows a homeowner aged 55 and older to sell his or her home and exclude up to $125,000 of capital gains from the Federal income tax remains in effect.

A number of important tax incentives having to do with the provision of rental housing were reduced or eliminated under the Tax Reform Act of 1986. There is a less generous depreciation schedule, limitations on the amount of rental loss that can be deducted by an investor, and the end of preferential capital gains taxation. Construction of new rental properties has dropped significantly in many parts of the country since 1986.

To increase the supply of rental housing units available and affordable to low-income households, including the elderly, the 1986 Tax Act created a new low-income housing tax credit for a 3-year period (1987 through 1989). The purpose of the low-income tax credit is to enable investors to be able to apply for 10 years of tax credits for new construction, or the substantial rehabilitation or purchase of existing buildings, where a specified percentage of units are set aside for low-income renters for at least 15 years.

OBRA 1989 extended the tax credit for 1 year, through December 31, 1990 (the House sought a permanent extension). OBRA 1989 also requires a 30-year extended low-income use agreement for credit eligibility. However, the law allows for conversion of the property to market rate use, under specified circumstances, but provides that existing low-income tenants may not be evicted within 3 years after the end of the compliance period. OBRA 1989 eliminated the availability of the tax credit to property receiving assistance under HUD's Section 8 moderate rehabilitation programs.

The 1986 Tax Reform Act also imposed new restrictions on tax-exempt bond financing used for multifamily housing. Instead of 20 percent of a building's units having to be set aside for families earning 50 percent or less of median area income, at least 40 percent of units must be reserved for those with 60 percent or less of median income. While most housing groups applaud the deeper targeting requirements believing this will mean more of the financing assistance will go to those who need help the most, some in Congress say that these and other changes have made it difficult to use tax-exempt bonds in areas that have particularly high housing costs, such as in New York City and parts of California.

The possibility that many federally subsidized housing units now occupied by low-income households could soon be legally withdrawn from the market by their owners or converted to higher priced rentals or to condominiums has over the past several years become a major concern to policymakers and proponents of low-income housing. Housing legislation enacted in 1989 ("Department of Housing and Urban Development Reform Act of 1989," P.L. 101-235) addressed this problem on what may be a permanent basis for housing programs under the FmHA (see discussion elsewhere in this chapter), and extended temporary solutions for other forms of federally assisted housing (see discussion elsewhere in this chapter). It is expected that legislation seeking more permanent solutions will be actively debated in the second session of the 101st Congress, particularly as part of the overall housing reform effort (see discussion of S. 566, the "National Affordable Housing Act").

Numerous technical amendments to the 1986 Tax Act were introduced in 1987 and 1988 that supporters of the new low-income housing tax-credit said were critically needed if this major new housing program is to produce anywhere near the number of units expected of it. As stated previously, OBRA 1989 extended the low-income tax credit for an additional year, through December 31, 1990.

(5) Farmer's Home Administration

The Reagan Administration tried, with little success, to dismantle most of the FmHA housing programs. It contended that FmHA played a minor role in providing housing assistance to rural areas and that the housing needs of rural communities would continue to be served by other sources. Opponents argued that the existing FmHA programs were not created in a vacuum, but were the result of congressional response to perceived needs, and that those needs continue to be unmet for many low-income rural residents. Housing vouchers, for example, will not enable low-income rural homeowners to improve their water and sewer systems.

Housing problems in rural America continue to be severe, particularly for those with low incomes. A 1989 report, "The Other Housing Crisis: Sheltering The Poor In Rural America," by the Center on Budget and Policy Priorities and the Housing Assistance Council, "some 27 percent of nonmetro[politan] elderly households were poor in 1985, compared with 19 percent of the elderly in metro areas." The report indicates that of these poor households, nearly 70 percent are those who live alone, and of these, most are women.

The administration's budget for fiscal year 1990 (the Bush Administration's first year) would have terminated most existing FmHA rural housing programs. Congress again rejected this and funded FmHA programs for fiscal year 1990, providing $1.32 billion for low-income, single-family loans (Section 502), and $580 million for rural rental housing loans (Section 515). The rural housing repair loans program (Section 504) is provided with $11.3 million.

The Housing and Community Development Act of 1987 authorized FmHA programs for 2 years, with loan and guarantee authorizations in fiscal year 1988 at $1.775 billion, in fiscal year 1989 at $1.795 billion, and in fiscal year 1990 at approximately $2.3 billion. It also, at the administration's request, authorized a 2-year FmHA rural voucher demonstration program in up to five States to provide up to 7,500 vouchers in each of fiscal years 1988 and 1989.

This demonstration program was to require participating States to complete an inventory of the local housing supply and to certify that there is an adequate supply of decent, safe, and sanitary low-income rental housing available for voucher holders in the State. However, the program was contingent on a specific appropriation to fund the units, and there were no appropriations for either fiscal year 1988 nor fiscal year 1989 for this 2-year demonstration project.

The 1987 law expanded the definition of domestic farm labor (for purposes of determining eligibility for Section 514 and 516 loans) to include retired or disabled farmworkers. Such persons are eligible to occupy assisted housing in places other than where they were employed as farmworkers if they wish to be closer to family members or to return to their home town.

(6) Home Equity Conversion

Developers hoping to find a lucrative market among the increasing numbers of elderly in the United States are learning that their competition is not with the retirement home, but in the single-family home. Economists estimate that there is as much as $750 billion of equity tied up in the houses of people older than 65. Thus, attention has been paid in recent years to financial arrangements that would permit aged homeowners to convert part of their equity into cash, without having to leave their dwellings. These home equity conversion plans (HECPs) offer a choice to elderly persons facing necessity-heavy budgets that have grown proportionately faster than their incomes. HECP's also could provide funds to allow older persons to pay for needed supportive services, home maintenance, and other needs. Before HECP's, the only source of equity borrowing available to older Americans was through the traditional financial institutions at high rates and short terms.

Homes are older Americans' most commonly held and most valuable assets. Three out of every four elderly persons own their homes and recent statistics indicate that 80 percent of these do not have a mortgage. Equally significant, a large portion of older homeowners are likely to have relatively low incomes. For example, 6 out of every 10 elderly single homeowners have incomes of $5,000 or less.

There are two distinct types of conversion plans—debt and equity—on which a variety of models are based. Debt plans allow an older homeowner to borrow against home equity with no repayment of principle or interest due until the end of a specified term of years, or until the borrower sells the home or dies. These plans can provide a single lump-sum payout to the borrower, a stream of monthly payouts for a given term or—with the addition of a deferred life annuity—guaranteed monthly payouts for life. They are often referred to as reverse mortgages or reverse annuity mortgages.

Property tax deferral programs, popular in many States, are a form of debt plan in which older homeowners postpone paying their taxes until they sell their homes or die. In State-initiated deferral programs, the State pays taxes to the local government for the homeowner. These payments accrue with interest as a loan from the State to the homeowner, secured by equity in the home.

Upon death or prior sale of the home, the loan is repaid to the State from the proceeds of the sale of the estate.

Equity plans involve sale of the home to an investor, who immediately leases it back to the seller. Land contract payments of the seller exceed term payments to the buyer, so the older person receives extra cash each month. In addition, the buyer pays the taxes, insurance, and maintenance. A deferred annuity or other investment purchased with the down payment can provide income beyond the land contract term. In light of recent tax reform activity, these plans referred to as sale/leasebacks, have been virtually eliminated.

The basic theoretical forms of HECP's have been established for several years. In general, however, workable instruments have yet to become widely available to the public. One reason for the lack of substantial interest is that the combination of financial benefits and risks associated with the plans have not been sufficiently attractive to borrowers. Moreover, lenders have also been reluctant to accept the risks associated with HECPs.

The HCDA of 1987 created a demonstration program to provide mortgage insurance for home equity conversion mortgages for the elderly. Under the demonstration, the FHA insures the mortgages and provides protections for both lenders and homeowners from the risks. The demonstration provides that a total of 2,500 mortgages may be insured by participating lenders through September 30, 1991. The mortgages are available to homeowners age 62 and older with little or no mortgage debt remaining on their homes. Rules issued by HUD to implement the program allow for the offering of three types of home equity conversion mortgages: (1) tenure; (2) term; and (3) line of credit.

Tenure mortgages provide for monthly payments from lenders to homeowners for as long as they occupy the home as a principal residence. Term mortgages provide for monthly payments for a fixed period agreed upon between the lender and the borrower. Line of credit mortgages permit homeowners to draw money at times and in amounts of their own choosing.

Under this demonstration program, the interest rate on the loans may be fixed or variable. However, the variable rate is capped at five points above the original rate and should only be provided on home equity conversion mortgages that provide either monthly disbursements that do not diminish for as long as the borrower owns the home as a prinicipal residence or a line-of-credit in which interest on each disbursement accrues at a fixed rate for the life of the mortgage, but different disbursements may be subject at different rates.

Homeowners retain ownership of their property and may sell and move at any time, retaining the sales proceeds in excess of the amount needed to pay off their mortgage. They cannot be forced to sell their homes to pay off their mortgage, even if the mortgage principal balance grows to exceed the value of their property. When the mortgage does come due, the lender's recovery from the borrower will be limited to the value of the home. There will be no deficiency judgment against the borrower or the estate.

HUD and the Administration on Aging joined together to fund the training of counselors to assist prospective borrowers in choosing a mortgage.

The demonstration loans became available for the first time in July 1989. HUD conducted a lottery to determine which financial institutions would participate in the demonstration. There were many interested institutions that were not selected in the lottery. Moreover, some 12,000 older homeowners have contacted HUD to express their interest in this program. In response to this demand, legislation was introduced in 1989 to expand and modify the demonstration program. Congressman Jim Florio, Chairman of the House Select Committee on Aging's Subcommittee on Housing and Consumer Interests, introduced a bill, "The Reverse Mortgage Insurance For Older Americans Act of 1989" (H.R. 3006) to increase the number of loans in the demonstration from 2,500 to 25,000. Senator Bob Graham introduced similar legislation (S. 1826) in the Senate, which is expected to be included in Senators Cranston and D'Amato's housing reform legislation, S. 566, in 1990.

(7) Prepayment

Probably the most controversial issue concerning assisted housing programs is that of prepayment of Federal loans and mortgages on assisted projects. In assisted FHA-insured projects, many owners have a contractual right to prepay their loan (without requiring permission) after 20 years (which typically would be for a 40-year period).

The reasons for prepayment vary. The projects may be in a condition and/or location that permits profitable sale for conversion to condominiums or to nonresidential use. In some instances (in Section 202 projects, for example) the borrowers argue that many projects are old and have suffered extensive deterioration as maintenance has been deferred. With many of these projects heavily in debt and unable to raise rents to support the cost of repairs, the project owners say that they have no way of rehabilitating the premises. Owners claim that if they were allowed to prepay their loans, the projects could be sold to profit-motivated owners who could afford private financing for needed repairs.

Other borrowers say that prepayment of loans should be permitted on projects no longer essential to the community. These are projects that were supplanted by newer developments. Borrowers believe that if they were permitted to repay the loans, their projects would be converted to other uses, still leaving adequate housing in the area for low-income tenants including the elderly.

Estimates vary as to the likely number of prepayments that may occur in the assisted FHA-insured stock. A recent report (discussed earlier in the chapter) by the National Low-Income Housing Preservation Commission (NLIHPC) states that 334,000 units of the 645,000 subsidized under Sections 221(d)(3) and 236 of the 1961 and 1968 Housing Acts will become eligible for prepayment over the next 15 years. The Reagan Administration estimated that about 306,000 units will reach 20 years of age between 1986 and 1996. HUD, taking market conditions into account, estimates that 154,000 of these are likely to prepay. In addition, an unkown number of the 850,000 project-based Section 8 assisted units may choose to "opt-out" of their contracts, or their contracts may expire within that same time period.

The GAO estimates that by 1995, the combination of expiring rent subsidies (i.e., 15-year Section 8 contract periods) and potential mortgage prepayments could reduce the current inventory of privately owned low and moderate-income rental housing by 200,000 to 900,000 units. According to the National Association of Home Builders, it would cost more than $130 billion to replace the existing stock of such housing. The NLIHPC reports that the preservation of 473,000 of the units in their study as low-income housing and assisting 50,000 displaced households would cost $17.7 billion over 15 years.

Housing activists fear that a monumental housing crisis is in the making. They note that this potential reduction comes at a time when Federal subsidies for low-income housing have been reduced by more than 70 percent over the past 8 years. Furthermore, tax reform has eliminated much of the incentive to invest in low-income housing, and the new administration appears to continue the Reagan Administration's commitment to not building any new subsidized rental housing.

The HCDA of 1987 tackled this issue with several interim measures. Essentially, the Act established that an owner of an eligible project (Section 221(d)(3) with rent supplement or Section 8 assistance, Section 221(d)(3) below market interest rate mortgages, Section 236 mortgages, or those involving the purchase of money mortgages originated by HUD in connection with the sale of HUD-owned projects) may prepay only in accordance with a plan of action approved by the Secretary of HUD.

Two lawsuits were filed challenging the constitutionality of the provisions. The plaintiffs (Thetford, a limited partnership which owns and operates multifamily housing in North Carolina, and Baker, a partnership that owns and operates a multifamily building in New Jersey) claimed that the provisions deprive them of their property without due process, and that it destroys their contract rights. The plaintiffs asked for $4 million (Thetford) and $8 million (Baker) in money damages. The courts unheld the statute. Anticipating such challenges, however, the HCDA included a 2-year moratorium on prepayments in the area subject to the court's decision, in the event the courts found the prepayment restrictions to be invalid.

Under the HCDA's prepayment provisions, an owner wishing to prepay or initiate other changes in the status or terms of the mortgage must file a notice with the Secretary and any appropriate State or local government agency. In addition, the Act provided for an owner's acceptance of certain incentives in exchange for an agreement to retain the housing for low- and moderate-income use for the remaining term of the mortgage. Those wishing to prepay would be required to submit a plan of action that must be approved by the Secretary of HUD. These plans of action will differ markedly from project to project. For example, an owner seeking to prepay the mortgage and terminate the affordability restrictions would be expected to provide detailed information on the impact of such actions on the current tenants and the local supply of low-income housing.

For owners demonstrating a willingness to keep the housing affordable to low- and moderate-income households, the HCDA authorized the Secretary to offer the owner a package of incentives. These incentives include an increase in the rate of return on equity, the provision of additional Section 8 assistance, or an increase in rents under existing contracts, or the provision of a capital improvement loan.

In formulating incentives, the Secretary is to take into account local market conditions and tenant populations. Wherever possible, State and local agencies are expected to take a leading role in finding appropriate solutions for projects. According to the HCDA, an array of Federal, State, and local incentives will be needed to solve the prepayment problem.

The prepayment provisions require the Secretary to provide timely written assessments and final approval of submitted plans. Two kinds of plans are called for: Those that request permission to prepay a mortgage; and those that request incentives to keep the housing affordable to low-income tenants. Each of the two types of plans have different approval criteria. For the first type of plan, the Secretary must ensure that implementation of the plan will not create hardships for current tenants or materially affect the general supply of low-income housing in the area. For the second type of plan, the Secretary must ensure, among other criteria, that the housing will be maintained as low-income housing for the remaining term of the mortgage, that any rent increases for current tenants would phase in over 3 years, and that vacant units will have rents affordable to low-income tenants.

Those who formulated this legislation noted that a number of private sector task forces (including those established by the National Housing Conference, the National Corporation for Housing Partnerships and the Advisory Council of HUD Management Agents), as well as State and local organizations, had undertaken a review of the options and alternatives available to respond to the loss of low-income housing.

They noted that an adequate supply of low-income housing has always depended on a strong long-term partnership between the public and private sectors that accommodates a fair return on investment. Reductions in the Federal housing budget and changes in tax benefits previously associated with low-income housing have increased incentives for private industry to withdraw from the production of low-income housing. The provisions within the 1987 HCDA are based on the premise that efforts to preserve low-income housing must be designed with the unique financial and market conditions of individual projects in mind.

It was the intent of Congress that these provisions would be emergency stop-gap measures to be used to avoid the irreplaceable loss of low-income housing and the displacement of tenants. Scheduled by the HCDA to expire on February 5, 1990, the prepayment provisions are now in effect until September 30, 1990, as a result of the "Department of Housing and Urban Development Reform Act of 1989" (P.L. 101-235), to provide additional time for more long-term solutions to be found. The 1989 law also included several provisions to clarify and modify various provisions from the 1987 law, including ensuring that owners get extended Section 8 rental assistance contracts, contingent upon the availability of appropriations, as part of their approved plan of action, and outlines protections for owners in the event the Secretary cannot provide for extended Section 8 rental assistance. The 1989 modifications also require that the plan of action specify actions that the Secretary and the owner shall take to ensure that any tenants displaced as a result of a plan of action, are relocated to "affordable housing."

(8) Bricks and Mortar Versus Supportive Services

During a period when there have been major reductions in Federal assistance for housing, there is growing concern about the need for additional supportive programs for those residents who are becoming frail or disabled to the degree their ability to remain living independently is at risk. The primary Federal focus on the "bricks and mortar" aspect of housing fails to address the supportive service needs of those being assisted. Further, this emphasis tends to discourage the development of other shelter alternatives that incorporate such services.

Since 1971, public housing authorities have had the authority to use Federal funds for the provision of dining facilities and equipment in public housing projects. No subsidy was to be provided to cover the cost of meals and other services. To date, there has been little development of these congregate facilities. A study on long-term care released by the DHHS in 1981 cited a variety of reasons for this, including local housing agencies having had little experience in managing the necessary services, little Federal encouragement and support, and no assurance of funds to pay for the services on an ongoing basis. Most services have been provided by local service agencies funded by the Older Americans Act, Medicaid, and the Title XX Social Services Act.

The philosophy of Section 202 housing is to foster independent living. Section 202 projects were not intended to be either intermediary care facilities or standard apartment rental units. Instead they were meant to provide shelter plus services appropriate to the needs of the elderly and handicapped. Although Section 202 projects for the elderly originally were designed to serve healthy older persons, survey results show that the majority of Section 202 tenants are "aging in place" and are now in need of more supportive-type services than when they entered the projects. This is true, also, for many tenants of public housing, as well as for those residing in other settings. The results of a recent survey of the Nation's Section 202 sites conducted by the University of Illinois at Urbana-Champaign, with support by the AARP, issued by the House Select Committee on Aging's Subcommittee on Housing and Consumer Interests, reveals that the average age of tenants in Section 202 projects for the elderly has increased to over 75. In the older 202 projects, 35 percent of residents are over the age of 80. Survey results also indicate that in the older projects, over 15 percent of tenants are considered by project administrators to be frail. These figures are only likely to increase over the next several years.

Although an average of six on-site services are offered per project, the types of services (such as personal care and housekeeping) that will enable the "aging in place" population to remain independent are offered on a very limited and fragmented basis. There is no Section 202 services model that applies to all projects in this program. As a result, project sponsors are free to interpret service needs however they choose. In the future, Congress will need to develop uniform guidelines to ensure that Section 202 sponsors will provide supportive service to help their aging populations to remain in their dwellings as they age, rather than be institutionalized.

In 1985, 28.5 million people (11.9 percent of the population) were 65 years of age or older. Of these, 1.3 million were living in nursing homes. Since the disabilities of nursing home residents vary from old age to severe handicaps, many of these people may be candidates for congregate housing. While there is no way of precisely estimating the number of elderly persons who need or prefer to live in congregate facilities, groups such as the Gerontological Society of America and the AARP have estimated that a large number of people over 65 and not living in institutions or nursing homes would choose to relocate to congregate housing if possible.

According to a 1989 report by the Urban Institute, "Providing Supportive Services To The Frail Elderly In Federally Assisted Housing," an esitmated 105,000 residents of assisted housing who are age 65 and over require help in at least one activity of daily living; this is some 7 percent of the total over-65 population that reside in assisted housing. According to this same report, this number "is less than the one-third of elderly assisted housing residents who have some degree of frailty."

In addition, many believe that there are many elderly residents of nursing homes and other institutions who had no other choice of residence due to lack of alternatives adapted to different levels of independence, even though they did not require skilled nursing care. The recent Section 202 survey report cited earlier indicates that nearly half (48.6 percent) of the residents of 202 projects for the handicapped come directly from institutional care, "indicating a significant deinstitutionalization effect from the program."

Since funding for housing programs has been reduced dramatically in recent years, some States have established their own housing initiatives, including congregate housing programs in an effort to provide their elderly citizens with needed care without relying on Federal funds. In the last few years, private developers have shown a growing interest in development of congreagte housing. Congregate housing appears to be a viable alternative for housing the semi-independent elderly.

(a) Congregate Housing Services Program

The Congregate Housing Services Program (CHSP) was originally authorized in 1978 as a demonstration program. The program was designed to help the elderly remain in rented dwellings as they age, rather than be institutionalized. During the demonstration, HUD extended multiyear grants (3-5 years) to eligible public housing agencies and nonprofit Section 202 sponsors for meals and other support services for frail elderly and nonelderly handicapped residents. As of 1988, $35.5 million had been obligated to grantees. Sixty grantees are in operation, serving approximately 2,000 residents.

This highly successful program was a target of the Reagan Administration, which sought annually to eliminate funding for the program. The Bush Administration seems to be continuing this effort, but it appears they wish to replace it with their own initiative to recognize the supportive services needs of the frail elderly.

Throughout the Reagan years Congress kept the program alive, appropriating funds for the maintenance of existing CHSP sites. The HCDA made CHSP a permanent program, authorizing $10 million for each of fiscal years 1988 and 1989. The HCDA also stated that a project is not required to provide a set number of meals, as long as the nutritional needs of the frail elderly are met. This was in recognition to the fact that a substantial portion of the program's funds were going to providing two meals a day, a expense and service that many, including HUD evaluators, questioned. The fiscal year 1988 appropriation for CHSP was $4.2 million; for fiscal year 1989 it was $5.4 million; and for fiscal year 1990 it is $5.8 million. While the funds authorized and appropriated for CHSP do not represent a significant increase over previous years, they do represent a congressional commitment to the program that has endured despite repeated attempts from HUD and the administration to eliminate it.

Of even more significance to proponents of congregate housing services is that current efforts to reform Federal housing programs specifically build upon the successful record of the CHSP. S. 566, the National Affordable Housing Act, introduced by Senator Cranston, includes a separate title devoted to "housing for persons with special needs," and would establish include programs that exclusively serve the elderly, persons with disabilities, homeless persons, or other persons "with special needs requiring supportive services related to their housing." In addition, as discussed earlier, the Bush Administration is expected in early 1990 to propose, as part of its major housing program (HOPE—Homeownership and Opportunity for People Everywhere), a demonstration project to provide vouchers to enable low-income frail elderly persons to help pay for needed supportive services.

(b) Mandatory meals

In 1987, HUD published final rules on mandatory meals programs in Section 202 units. The rule authorized mandatory meals programs already in existence, but not in any new programs in existing or future projects. In formulating these rules, HUD took into consideration a number of opposing arguments, and views the rule as a compromise between protecting residents' rights and independence as well as ensuring their nutrition, and protecting sponsors' housing-and-services ideal.

This was the result of a vigorous debate, with strong views on both sides of the issue. A 1985 GAO study found that only 512 of the 903 sponsors of 202 projects offered meals programs, and only 98 of those were mandatory. Seventy percent of residents participating in the mandatory programs reported that they were satisfied with them, and 80 percent of all residents in mandatory programs indicated they would not leave the program if permitted. Only 17 percent of residents dislike the mandatory meal program.

Many advocates for the elderly object to mandatory meals. They believe that forcing a resident to participate in a meal program when he or she could and would prefer to prepare his or her own food appears to be an infringement on individual rights and contradicts the support for elderly independence to which Section 202 sponsors are dedicated. Those in support of the program cite the fact that the adequate nutrition of elderly residents is a primary concern of Section 202 sponsors, arguing that many residents do not take the time, have the interest, or even remember to eat properly. Furthermore, as they age in place, residents increasingly are unable to prepare meals for themselves. Twice as many residents over 80 experience this difficulty, compared to those between 62 and 79.

Proponents also argue that mandatory meals address the isolation of some residents by encouraging them to get out of bed, get dressed and leave the isolation of their rooms for the more social atmosphere of the dining room. Daily meals also help project sponsors conduct informal "resident checks" thus aiding in awareness of which residents are ailing or missing.

It is evident that there are benefits derived from meal programs, but there is some question about whether it is necessary to maintain the mandatory status of existing programs, in order to offer a meal program. Ninety-two percent of mandatory meal managers believe that they could not continue to provide meals if forced to make the transition to a voluntary program. At the very least, they believe that meal prices would increase because the program receives no Federal money and runs with a very small profit margin.

Currently operating mandatory programs were established in good faith with HUD's permission, and some argue that forcing them to make what is predicted to be an unsuccessful transition to voluntary status is unfair. The GAO advised against prohibiting these programs, acknowledging the risk of eliminating meals programs entirely.

3. Prognosis

For advocates of a strong Federal role in meeting the housing needs of the Nation's low-income citizens, 1989 was a year of both major disappointments and renewed optimism that the downward decline of the Federal role during most of the past decade would be reversed in the near future.

As 1989 began, and the new administration took office, there was great hope that major housing reform efforts initiated in 1988 would receive serious attention during the year and that new legislation might be enacted. In particular, their hopes were focused on the comprehensive legislation being developed by Senators Cranston and D'Amato, chairman and ranking minority member respectively, of the Subcommittee on Housing and Urban Affairs of the Senate's Committee on Banking, Housing, and Urban Affairs.

Instead, the year was dominated by the continuous unfolding of scandals at HUD and in federally assisted housing programs. The seemingly daily news coverage of favoritism, profiteering, and the virtual absence of accountability captivated congressional, as well as Secretary Kemp's, attention.

As a result, proponents of an increased Federal role do not expect to see a sudden infusion of Federal dollars into housing assistance, especially for new construction. They do see, however, the opportunity to make some modest incremental steps toward revitalizing the Federal role. Both the Congress and the Administration have indicated their commitment to this effort, recognizing, as do the States and the private sector, that the Nation's housing problems, including those faced by the elderly, are not going to resolve themselves and cannot be handled by the States, local communities, or the private sector in the absence of a strong Federal role.

Two major initiatives in 1990 offer the hope that major housing reinvigoration and reform is likely, perhaps in 1990. The first is the Cranston-D'Amato legislation, and the second is the administration's HOPE—Homeownership and Opportunity for People Everywhere—initiative, which was included as part of the administration's fiscal year 1991 budget proposal. Also, Representative Henry Gonzalez, chairman of the House Banking Committee's Subcommittee on Housing, is expected to reintroduce his housing reform legislation in 1990.

The Cranston-D'Amato legislation is a sweeping package of initiatives that would address major facets of America's housing needs. A major component of the legislation would establish a new HOME corporation to bring State and local government into a new partnership with the Federal Government and the not-for-profit and private sectors, to provide more affordable housing. This would be done through the creation of the Housing Opportunity Partnerships (HOP) program which would have a revolving housing investment trust fund offering a line of credit to states and localities, with funds offered on a matching basis. The legisltion would also: Provide incentives for aspiring first-time homeowners to save for their downpayments; tackle the affordability of rental housing, by combining the best features of Section 8 certificates and vouchers; and create a new Office of Affordable Housing Preservation to oversee new incentives to keep federally assisted housing in stock and well-maintained.

Of particular significance to the elderly would be a new title, Housing for Persons with Special Needs, to specifically address the needs of the elderly, persons with disabilities, and the homeless. For the elderly, the Section 202 program would continue with a new funding system that requires much less budget authority per unit, and the manner in which tenant rents are computed would be changed—which should ensure that the "pipeline" problem (discussed earlier) would be ameliorated. Elderly housing would be designed to (1) meet the special physical needs of the elderly, including those who are frail, and (2) accommodate supportive services needed by these individuals. A "Project Retrofit" would upgrade existing elderly housing, making new forms of HUD assistance available only when a project receives assurance that long-term funding for supportive services will be provided by State, local or other sources.

All of these reforms would be under the jurisdiction of a newly created Office of the Assistant Secretary for Supportive Housing.

The Assistant Secretary for Supportive Housing would be responsible for the administration of housing programs that serve the elderly, handicapped and homeless, and would also serve as HUD's liaison with the DHHS and other agencies on matters relating to supportive services for special tenant populations served by HUD housing programs.

The administration's HOPE initiative would also address the supportive services needs of the frail elderly, although on a much more limited basis. A demonstration program would be established that would link vouchers with other assistance to help the frail elderly to pay for needed services. The HOPE initiative would also address various other major housing issues through such proposals as providing opportunities for low-income tenants of federally assisted housing to purchase properties when owners decide to opt out of the Federal programs, and extending low-income tax credits to the private sector for construction and rehabilitation of low-income housing.

Advocates are encouraged that the administration will push a housing reform initiative. Many would argue, however, that the extent of the President's commitment to housing low-income Americans is measured by his support for funding housing programs in fiscal year 1991. The news on this front is not reassuring. The President's budget proposal for fiscal year 1991 would dramatically reduce funding for the Section 202 program. Budget authority for 202 housing has decreased 81 percent since 1981; for fiscal year 1991, the number of new 202 units for the elderly and disabled would be reduced from less than 8,500 in fiscal year 1990 to 3,967—another 53-percent reduction. The administration proposes, however, to fund 3,000 units of leased housing for the elderly and handicapped. Furthermore, the President proposes a consistent theme from the Reagan years: elimination of the CHSP, which would be replaced by the "Service Supported Housing Voucher Demonstration Program for the Frail Elderly" described earlier.

Although the housing needs of low-income Americans are becoming an increasingly important concern to politicians and the American public alike, enactment of a comprehensive housing bill in 1990 is not a certainty. Barring the passage of legislation in 1990, it is important that Congress not permit any further erosion of funding for housing. While over the past 9 years there has been a steady and significant erosion of Federal financing for housing, Congress has not acquiesced in proposals to terminate key housing programs, including congregate services for the elderly, and is unlikely to do so in the future.

While the role of the Federal Government still remains significant because of its prior subsidy programs, it is clear that the Federal role continues to diminish and, when major reform legislation is enacted, the Federal role is unlikely to be on the scale it has been in the past. State and local commitments to public housing have become very important and will continue to be even more important. Nonetheless, the level of State and local support varies widely, and few States have adequate resources to support adequate programs.

Although reductions in direct Federal spending on housing programs can be expected to result in some amount of replacement spending by the private sector, it is evident that it will not supplant the Federal role in meeting the needs of low- and moderate-income households and neighborhoods. The necessity for Federal leadership and resources is becoming increasingly evident to virtually all concerned about housing. Whether or not legislation is enacted in 1990, the second session of the 101st Congress will see a great deal of debate and action on reinvigorating the Federal commitment to the objectives of the 1949 Housing Act: Safe and affordable housing for all Americans.

B. HOMELESS SERVICES

1. Background

Since the 1982–83 recession, the plight of the Nation's homeless and hungry has attracted a great deal of concern and publicity. Although reliable statistics are hard to find, it is clear that a large number of Americans are homeless. HUD unleashed a storm of controversy with a 1984 report that concluded that there were only 250,000 to 350,000 homeless persons nationwide. Other groups that work with the homeless insist that the total is about 10 times that amount. In a report which examined estimates of the numbers of homeless persons published between 1975 and 1987, the GAO concluded that because of flawed data gathering methods, none of the estimates are sound. A more recent calculation was issued by the Urban Institute in 1988. Using a sample which represented only those homeless persons who used meal and shelter services in 20 cities with populations over 100,000, the Urban Institute estimated the number of homeless to total between 567,000 and 600,000.

The National Alliance to End Homelessness calculates that on any given night, there are 735,000 homeless people in the United States, and that 1.3 million to 2.0 million people will be homeless for 1 night or more during 1988.

While no one knows precisely how many Americans are going hungry or are malnourished, institutions involved in providing emergency food assistance have seen dramatic increases in the numbers of people seeking assistance during the past few years. According to a report released in December 1989 by the U.S. Conference of Mayors of a survey of city officials in 27 major cities, requests for emergency shelter in 1989 rose by an average of 25 percent from 1988. The rise in requests for food remained at an average of 19 percent.

Homelessness stems from a variety of factors, including unemployment, social service and disability cutbacks, lack of aftercare services for the deinstitutionalized mentally ill, noninstitutionalization (the failure to treat people who need a hospital environment), personal crises, substance abuse, and housing shortfalls in urban areas. The chronically mentally ill comprise one of the largest portions of the homeless, between one-fourth and one-third of the total. According to the Reagan Administration's Interagency Task Force on Food and Shelter for the Homeless, the number of patients in mental hospitals dropped from 560,000 in the mid-1950's to 100,000–150,000 in the early 1980s. In some cities, veterans of Vietnam or earlier conflicts are thought to make up one-third to one-half of the homeless. The fastest growing segment among the homeless, however, is unemployed individuals and their families. The 1989 U.S. Conference of Mayors report states that families demanding shelter increased by 23 percent and represented one-third of the homeless in the cities surveyed. Recent studies also have documented a new dimension—the suburban homeless. In some relatively affluent suburban communities with rising housing costs, families who earn the minimum wage, or barely above it, cannot afford apartments or houses, and instead, are living on the streets, in publicly funded shelters, or in their automobiles.

A 1987 report by the National Coalition for the Homeless estimates that 15–20 percent of the homeless are over age 60. For those elderly who are homeless, a great deal of the problem results from the lack of health care and affordable housing due to skyrocketing rents, elimination of single-room-occupancy hotels, and a shrinking supply of low-income housing. Given the decline in Federal housing assistance during the Reagan years, the housing needs of low-income households cannot be met. In the meantime, the number of people on waiting lists for low-income public housing continues to rise.

Earlier in this decade the policy of deinstitutionalization was credited as a leading cause of homelessness in America. However, deinstitutionalization was initiated over 25 years ago, and most surveys report only modest percentages of homeless people are former residents of mental hospitals. Today observers focus on "noninstitutionalization" (individuals lack of access to or choice of no mental health treatment) as a critical problem.

In the past, Congress responded to the problem of homelessness with legislation that was essentially of an emergency nature, primarily because homelessness was perceived as a temporary crisis. The major programs authorized in the 98th Congress were the Emergency Food and Shelter Program (P.L. 98–8) funded through the Federal Emergency Management Agency (FEMA) and the Temporary Emergency Food Assistance Program (TEFAP) administered by the Department of Agriculture (P.L. 98–92). In the 99th Congress, statutes governing various welfare programs were amended to provide for the needs of the homeless through provisions included in the Homeless Eligibility Clarification Act (Title XI of the Anti-Drug Abuse Act of 1986, P.L. 99–570). Among the new provisions were removal of restrictions limiting food stamp eligibility of homeless persons living in shelters, Supplemental Security Income payments to eligible homeless persons, and establishment of methods of delivering veterans' benefits to persons lacking a mailing address.

Legislative efforts to expand assistance to the homeless were among the first items on the agenda of the 100th Congress. Most Members of Congress believe that solutions to the problem of homelessness should be developed at the local level. Unlike the Administration, however, Congress believed that the Federal Government had an important role to play in the solution to the homeless problem. In January 1987, Congress passed a measure reallocating $5 million in disaster relief funds to programs aiding the homeless (P.L. 100–6).

Congress followed up with the Stewart B. McKinney Homeless Assistance Act which was signed into law on July 22, 1987 (P.L. 100-77). In parallel action, congressional conferees for the fiscal year 1987 supplemental appropriations bill, H.R. 1827, agreed to appropriate most of the funds for the programs included in the McKinney bill, and that measure also was signed into law in July 1987 (P.L. 100-71).

Following is a summary of the authorized provisions under various programs contained in the Stewart B. McKinney Act:

Federal Emergency Management Agency

Authorizes an additional $8 million for fiscal year 1990 for a total of $134 million for the emergency food and shelter program. The fiscal year 1989 authorization was $126 million.

Department of Housing and Urban Development

(1) Emergency Shelter Grants Program (Title IV-V) authorizes grants to States, local governments, and private nonprofit organizations providing assistance to homeless individuals according to the community development block grant program formula. Eligible activities include renovating or converting buildings for use as emergency shelters, providing essential services concerned with employment, health, drug abuse or education (if not provided by local government and not to exceed 15 percent of assistance), and covering the cost of maintenance, insurance, utilities and furnishings. Each grantee is required to match the grant with funds from other sources.

(2) Supportive Housing Demonstration Program (Title IC-C) authorizes financial and technical assistance to States, local governments and private nonprofit organizations for the provision of transitional housing and supporting services for the homeless, including permanent housing for homeless handicapped persons who are capable of moving into independent living.

(3) Supplemental Assistance for Facilities to Assist (Title IV-D) the Homeless authorizes awards to States, cities, urban counties, tribes, or private nonprofit organizations to cover costs in excess of assistance provided under the emergency shelter grant or the supportive housing demonstration programs or provide comprehensive assistance for particularly innovative programs or alternative methods of meeting needs. To the extent practical, at least 50 percent of the funds are to support projects with primarily benefit homeless elderly individuals and homeless families with children.

(4) Assistance for Single Room Occupancy Dwellings (Title IV-E) authorizes competitive awards for the rehabilitaion of single-room occupancy units to be used solely to house the homeless.

(5) Identification and Use of Surplus Federal Property (Title V) authorizes HUD to locate underutilized Federal property that might be converted into housing for homeless individuals and authorizes the GSA and DHHS to make the buildings available to States, local governments, and nonprofit agencies.

Department of Health and Human Services

(1) Health Services for the Homeless (Title IV-A) authorizes grants through the Health Resources and Services Administration

to public and nonprofit private entities for delivery of outpatient primary health services and substance abuse services to homeless individuals.

(2) Community Mental Health Services for the Homeless (Title VI-B) authorizes a block grant to the States to provide outpatient mental health services to homeless people who are chronically mental ill.

(3) Community Mental Health Demonstration Projects for Homeless Individuals who are Chronically Mentally Ill (Title VI-B) authorizes demonstration grants to State, local governments, and private nonprofit organizations to provide community-based mental health services to homeless individuals who are chronically mentally ill.

(4) Community Demonstration Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals (Title IV-B) authorizes grants, contracts, and cooperative agreements to develop and expand alcohol and drug abuse treatment services for homeless individuals. At least 1.5 percent of the appropriated amount is to be allocated to Indian tribes.

(5) Emergency Community Services Homeless Grant Program (Title VII-D) authorizes additional Community Services Block Grant funds to be allocated to States according to the same formula set forth in the Community Services Block Grant Act.

(6) Study of Youth Homeless (Title VII-E) is authorized to be awarded by the Secretary for a recipient to research the underlying causes of youth homelesseness.

Department of Education

(1) Adult Education for the Homeless (Title VII-A) authorizes a program of "Statewide Literacy Initiatives" for grants to the Sttes to develop a plan and implement a program of literacy training and basic skills remediation.

(2) Education for Homeless Children and Youth (Title VII-B) authorizes State grants to establish an Office of Coordinator of Education on Homeless Children and Youth in each State to assure that homeless children have access to public education.

Department of Labor

(1) Job Training for the Homeless (Title VII-C) authorizes job trainging demonstration grants for the homeless.

(2) Homeless Veterans Reintegration Projects (Title VII-C) authorizes grants to expedite the reintegration of homeless veterans into the labor force.

Department of Agriculture

The Temporary Emergency Food Assistance Program was reauthorized and amended by the Hunger Prevention Act (P.L. 100-435). The program allocates federally donated foods and some administrative funding to the states.

In addition, the McKinney Act established a 3-year Interagency Council on the Homeless, composed of most Cabinet Secretaries and the heads of several independent agencies.

The 100th Congress reauthorized the McKinney Act for fiscal year 1989 and fiscal year 1990 (P.L. 100-628), adding programs for homeless veterans and homeless families who receive AFDC benefits. In addition, Congress reauthorized the Runaway and Homeless Youth Program as part of the Omnibus Drug Initiative (P.L. 100-690).

The 101st Congress addressed the questions of whether to provide additional fiscal year 1989 funding for programs benefiting the homeless and what levels to fund these programs for fiscal year 1990. Well over 100 members of the House cosponsored legislation (H.J. Res. 31) that, if enacted, would have made an emergency supplemental fiscal year 1989 appropriation to fund up to fiscal year 1989 authorization levels for certain McKinney Act programs. Fiscal year 1989 supplemental appropriations totaling $135.5 million for the HUD, FEMA, and VA homeless programs were included in the "dire emergency supplemental appropriations bill" (H.R. 2072) as originally reported by the House Committee on Appropriations. The Bush Administration opposed the increased McKinney Act programs in H.R. 2072. However, both chambers of Congress passed H.R. 2402 which included $12 million transferred from HUD to FEMA for the Emergency Food and Shelter Program. The McKinney Act programs are authorized through fiscal year 1990 and in some cases through fiscal year 1991.

2. ISSUES

(A) PRIVATE AND PUBLIC SECTOR ROLES

Most would agree that homelessness is a problem deserving the attention of policymakers. However, Federal responsibility for the homeless continues to be a matter of considerable debate. The Administration and others maintain that the problem is best addressed at the local level through religious and charitable groups. Others maintain that the problem would be better addressed through a comprehensive set of federally-assisted programs and benefits. The proactive approach to homelessness views the problem as prevalent across America and beyond the capacity of State and local responses. Those adhering to this approach maintain that the Federal Government should assume responsiblity for alleviating the problems that contribute to homelessness because the causes can best be addressed nationally.

Current responsiblity for the homeless is dispersed among all levels of government. The Federal programs generally required local and State-level planning and integration. The largest single Federal appropriation is coordinated, dispersed and monitored by a national board of local charities and religious organizations. However, it is administered by the FEMA.

Another facet of the problem concerning the role of Government are the questions of how much relief can result from government efforts and how far governments should go in addressing the homelessness issues. Even if services were readily available, an unkown portion of the population may be reluctant to accept them, raising essential questions as to what can or should be done to impose services on them. A subtle indication of this has emerged in a few major cities which have or are considering new ordinances to temporarily detain mentally ill homeless or others refusing to accept shelter from the elements. And since so much of the homeless problem is thought by many to involve the chronically mentally ill, questions have been raised about whether more control can be exerted over patient releases and long-term institutionalizations.

Private and public resources have been mobilized to attempt to meet the immediate needs for foof and shelter. Shelters and other facilities available to the homeless generally are provided by private groups, sometimes with financial help from local governments. In addition to emergency shelters, some localities provide families or individuals with certificates or vouchers to help pay the rent. Vouchers may also be given to destitute people to enable them to rent rooms in single-room occupancy buildings or hotels.

Something of a new frontier in the law recently has begun to develop in the realm of rights of homeless individuals. In the face of housing shortage, homeless people are increasingly turning to the courts for assistance, and judges have started to define their rights. While the Constitution does not explicitly guarantee a right to shelter, judges have ordered State and local officials to provide shelter based upon State constitutions and statutes, and upon provisions in the Federal law. It can be expected that advocates for the politically powerless homeless will continue to use the courts to obtain and to enforce the basic rights of, and to obtain benefits for, the homeless.

One experimental project initiated in 1987 to reach the homeless elderly has been conducted by the Indiana Department of Aging with Older Americans Act funds. Three area agencies on aging worked with older persons who were either homeless or marginally housed in an attempt to find long-term solutions to the housing problems of those persons through employment. An enrolled person received assessment of employment needs and skills, individual counseling, job-readiness training, peer group support through job clubs, wages for work experience, and skills training through existing programs such as the Job Training Partnership Act and Community Services Block Grant programs.

In Boston, a group of concerned citizens formed the Elderly Homeless Coalition, and developed a plan to provide rooms and meals, health, mental health, and case management services for the city's homeless elderly.

The Emergency Food and Shelter program, currently administered by the FEMA, has provided more than $400 million for food, shelter, and other forms of assistance to the homeless. The program was initiated in the Emergency Jobs Appropriations Act approved in 1983 (P.L. 98-8), and has continued through appropriations, supplemental appropriations, and a continuing resolution in subsequent years. The 101st Congress, for example, passed H.R. 2402 making supplemental appropriations for fiscal year 1989 for this program which included $12 million transferred from HUD to FEMA.

By most accounts, the FEMA program, which utilizes local programs rather than duplicating their efforts, has worked well. In 1989, the FEMA program funded about 29 million fewer meals than 1988 at a cost of $55 million. "Meals" includes meals provided on site, vouchers for meals, and meal counts from food banks. A meal provided from these funds is estimated to cost, on average, 69 cents. The estimated cost of a night in a shelter is $2.94. "Shelter" includes motels/hotels and 1 month's rental assistance as well as actual shelters. The total cost in 1989 for shelters was $50 million.

Citizens in cities across the country have voluntarily donated time and money to help feed the hungry and house the homeless. But even with these efforts, optimistic statistics revealed that only one in three homeless individuals had a bed and a bowl of soup in a public or private shelter in the winter of 1988. Other figures suggest that only 1 of 20 were so fortunate. Both figures illustrate how much has yet to be done. The HUD report, for example, states that in 1988 there were about 275,000 shelter spaces available nationwide for as many as 500,000–600,000 homeless, indicating a serious shortage. Moreover, these shelters are at risk in many communities because of neighborhood opposition, inner-city redevelopment, and other factors. More recently, the U.S. Conference of Mayors reported that in the 27 cities they surveyed, 24 percent of the requests by homeless people for emergency shelter went unmet and the demand for emergency food frequently goes unmet.

(B) FEDERAL HOUSING PROGRAMS

Advocates for the homeless as well as some researchers and housing experts argue that the lack of affordable housing is the chief cause of homelessness. Federal expenditures for low-income housing continues to decrease while the number of people needing such housing has increased (as discussed earlier in this chapter). In addition, much of the public housing that has been built over the past half century is obsolete and deteriorating.

Homeless advocates argue for a national housing policy and a resurgence of Federal spending for the construction and renovation of public housing and for a larger housing voucher program. Some express the belief that a remedy to the shortage of low- and moderate-income housing is the only systemic solution to homelessness.

Critics of an expansion of federally assisted housing maintain that such spending cannot be accomplished in a time of Federal deficits and budget constraints, expressing the view that incentives to the private sector are a better way to stimulate housing growth. They also assert that the changes in the Federal Government's housing programs have not caused homelessness. Furthermore, they argue that where there are shortages of low- and moderate-income housing units, it is largely due to local government policies, particularly rent control.

(C) EMERGENCY SHELTERS AND WELFARE HOTELS

When homelessness originally was thought to be a temporary crisis, it was generally agreed that shelters were a reasonable response. Some now fear that what is called a "shelter industry" has emerged, created in large party by Federal money. This argument states that shelters are transforming from temporary facilities to self-perpetuating institutions. Some maintain that the growth of these shelters has attracted people to homelessness, making nomadic street life and panhandling a now viable alternative for those who choose not to be productive members of society.

The use of Emergency Assistance (EA) and Aid to Families with Dependent Children (AFDC) money to house families in commercial, transient accommodations, commonly referred to as "welfare hotels," is an especially controversial practice. Reports that the costs of housing families in hotels far exceed the normal housing allowance for welfare recipients and the media exposure of the plight of those who reside in these settings fuel the debate.

At one end of the spectrum are those who would forbid the use of these funds for such purposes, maintaining that the practice is inappropriate and wasteful. At the other end of the spectrum are those who view the practice as problematic, but essential given the currently available range of programs and services. They point out the AFDC housing allowances often are insufficient, even for low-income housing. Emergency shelter providers also report that they cannot meet the demand for space and that welfare hotels are a last resort.

In December 1987, the DHHS proposed new regulations restricting the use of EA and AFDC funds for the purpose of housing in hotels. Congress, however, prohibited DHHS from implementing these regulations during fiscal year 1988.

The McKinney Act has authorized a new demonstration grant program for fiscal year 1990 which is intended to reduce the number of AFDC recipients who live in welfare hotels. The Bush Administration has proposed for FY91 to move this demonstration program from DHHS's Family Support Administration to HUD's Transitional and Supportive Housing Program. In addition, the 101st Congress is addressing the welfare hotel problem by offering amendments to the emergency assistance provisions of the AFDC program. These bills include proposals for demonstration projects to use emergency assistance to rehabilitate housing for AFDC recipients and to make grants to states to provide permanent housing for homeless families who would otherwise require emergency assistance.

(D) INSTITUTIONALIZATION

Some communities are enacting laws that allow local authorities to institutionalize the chronically mentally ill homeless without their permission. For example, recently a New York woman sued the city over her involuntary commitment to a mental hospital. Although the hospital ultimately released the woman, a higher court upheld the New York City law which provides for involuntary confinement in such cases.

The debate extends beyond the mentally ill homeless to include ordinances that detain any homeless person who refused to accept shelter from the elements. Questions of civil liberties and rights of the homeless will increasingly become an issue the resolution of which will be sought in the courts.

(E) HEALTH, SOCIAL, AND WELFARE SERVICES

The delivery of health, social, and welfare services to the homeless has also become an issue. Some maintain that many of the McKinney programs are not actually necessary because they duplicate existing programs. Community primary health and mental health centers are available to low-income people, including the homeless. When Congress removed requirements that recipients have permanent addresses to obtain certain benefits, it lifted the major legal barrier to providing services to the homeless. Thus, it is argued that instead of special public welfare programs for the homeless which complicate the provision of services at the local level and are potentially wasteful, local service providers should conduct more outreach to the homeless, aiding them with existing programs.

A widely held perspective maintains that funds for the homeless should be distributed as a block grant. This would enable State and local policy makers to make discretionary choices according to the varying needs of individual communities.

Others express the view that the homeless have special needs that are best handled by targeted services. While few assert that the Federal Government should establish a separate system of services for the homeless, many state that special programs geared for the acute needs of the homeless should be operated within the public welfare system. Advocates assert that if money is not earmarked at the Federal level for these specific programs, the homeless will lose to other competing demands for limited resources.

(F) IMPLEMENTATION OF THE 1987 MCKINNEY ACT PROGRAMS

In oversight and reauthorization hearings in 1988, Congress expressed concern with the slowness with which HUD was moving in approving the suitability of surplus Federal structures that could be made available to the homeless. In 1989 approximately 4800 excess and unused Federal properties were reviewed and just under one-half of those reviewed were found to be suitable for use by the homeless. Advocates for the homeless filed a lawsuit against HUD, the GSA, and three other Government agencies in an attempt to accelerate Federal action. A Federal court subsequently ordered HUD to review the surplus Federal properties for possible use by the homeless within 1 month. HUD remains under the same court order.

The 101st Congress may consider amending certain McKinney provisions to ensure faster implementation of housing-related provisions of the McKinney Act. More sweeping proposals aimed at providing permanent housing for the homeless as well as a comprehensive housing program have also been introduced.

There has also been congressional concern whether the Inter-Agency Council on the Homeless was fulfilling its duties. The Council was created by the McKinney Act to review and evaluate Federal agencies, work with States and local governments to coordinate programs, and to develop new programs for the homeless, and report to Congress. Due to the Council's unresponsiveness to congressional inquiries, in January 1989 the GAO was asked to undertake an investigation of the Council's activities.

GAO reported that the Inter-Agency Council on the Homeless had not adequately and effectively met its statutory responsibilities under the McKinney Act primarily due to a delay in defining its roles and goals. The GAO recommended that the Council's goals and responsibilities be clearly defined to ensure that urgently needed assistance intended by Congress and the McKinney Act will be provided to the homeless.

3. Federal Response

The primary response of the Federal Government to the plight of the homeless has been through the McKinney Homeless Assistance Act of 1987. However, that act authorized programs only through fiscal year 1988. Consequently, an omnibus measure authorizing a 2-year extension of the programs was introduced in the House of Representatives on March 31, 1988, as H.R. 4352. The conference report on H.R. 4352 passed in the House on October 19, 1988, and in the Senate the following day. The bill was signed by the President on November 7, 1988, and became Public Law 100-628.

In addition to reauthorizing existing programs under the McKinney Act, the new law incorporated provisions for homeless veterans and the "Jobs for Employable Dependent Individuals Act" (JEDI) to improve job training and placement for long-term welfare recipients and individuals under the JTPA. The Act also prohibits DHHS from promulgating proposed regulations to limit use of EA and AFDC funds for homeless families, and requires DHHS to recommend demonstration projects designed to reduce the number of AFDC families in welfare hotels. Other provisions encourage Federal agencies to identify unutilized as well as underutilized Federal facilities that can be used to shelter the homeless on a temporary basis, and encourage States to establish State Interagency Councils on the Homeless.

Although opposed to increasing McKinney Act appropriations up to levels authorized for fiscal year 1989, President Bush included increased funding for programs aimed at helping the homeless in his revision of the Reagan Administration's fiscal year 1990 budget proposals. The materials accompanying President Bush's proposed revision did not specify the funding levels in detail, but stated clearly that Bush was seeking funding for McKinney Act programs up to their full authorization levels—totaling $676 million. The amount initially appropriated in fiscal year 1990 for McKinney Act programs was approximately $600 million (see Table 1). Sequestration under Gramm-Rudman and the redistribution of money for emergency drug funding led to a revised fiscal year 1990 total of $596.2 million for major McKinney Act Programs.

The Bush Administration's fiscal year 1991 budget request for current McKinney Act programs (see Table 1) proposes a new HUD program—"Shelter Plus Care"— which would provide assistance to long-term homeless people who are mentally ill or have substance abuse problems. The program would be part of the Homeownership and Opportunity for People Everywhere (HOPE) grants that HUD Secretary Jack Kemp advocates.

TABLE 1.—FISCAL YEAR 1990 AND FISCAL YEAR 1991 FUNDING FOR MAJOR McKINNEY ACT PROGRAMS

[In millions of dollars]

Department or agency	Fiscal year—		
	1990 appropriated	1990 adjusted [1]	Bush 1991
Federal Emergency Management Agency:			
Emergency food and shelter	134.0	130.0	125.0

TABLE 1.—FISCAL YEAR 1990 AND FISCAL YEAR 1991 FUNDING FOR MAJOR McKINNEY ACT PROGRAMS—Continued

[In millions of dollars]

Department or agency	Fiscal year		
	1990 appropriated	1990 adjusted [1]	Bush 1991
Housing and Urban Development			
Emergency shelter grants	[2] 75.0	73.7	71.2
Supportive (transitional)	[2] 130.0	126.8	143.4
Supplemental assistance	[2] 11.0	10.8	
Section 8 (SRO)	[2] 75.0	73.7	49.6
Health and Human Services			
Health services for homeless	[3] 34.1	33.7	[4] 45.6 (12)
Community services for homeless	[3] 22.0	21.8	[4] 47.0 (8)
Community mental health	[3] 28.1	27.7	[4] 34.0 (7)
Mental health demonstrations	[3] 6.1	6.0	6.0
Alcohol/drug demonstrations	[3] 9.5	16.3	[4] 9.5 (1.5)
Homeless AFDC families demonstration	[3] 20.0	20.0	([5])
Education			
Adult literacy	7.5	7.4	10.0
Youth and children	7.5	7.4	7.5
Labor			
Job training (includes veterans' reintegration)	11.5	11.3	11.5
Veterans Administration			
Mentally ill veterans	11.5	15.0	15.0
Veterans' domiciliary care	11.5	15.0	15.0

[1] Incorporates emergency drug funding and GRH sequestration according to Administration budget document.

[2] H.R. 2916, Conference Report 101-297 (P.L. 101-144).

[3] H.R. 2990, Conference Report 101-274 (P.L. 101-166).

[4] These fiscal year 1991 funds were advanced fiscal year 1991 appropriations included in Public Law 101-156 (see Conf. Rept. 101-274). The fiscal year 1991 Bush proposal includes these advanced appropriations.

[5] The Bush proposal would move this program to HUD's supportive (transitional) housing program and is reflected in the increased fiscal year 1991 request for that program.

C. INNOVATIVE HOUSING ARRANGEMENTS

1. Background

The single-family house has come to represent the discrepancy between the supportive care needs of a burgeoning population of elderly homeowners and the lack of housing alternatives. Recently, several types of solutions to the problems of those elderly living in houses too large for their needs and too costly to maintain have surfaced. The previously discussed concern about meeting the needs of those older persons who have become too frail to live independently without adequate supportive services has led to increased attention to developing and utilization alternatives. Among the housing alternatives that continue to receive attention are board and care homes, life care communities, shared housing and ECHO, or "granny flat" arrangements.

2. Issues

(A) BOARD AND CARE HOMES

There are an estimated more than 1 million residents of the Nation's board and care facilities. These facilities, which go by many names—residential care, domiciliary care, adult homes, congregate living facilities, to name a few—typically serve a frail and disabled population by providing some form of supervision or protective oversight and some assistance with personal care. In additioin to providing a home for these residents, these facilities are receiving increased attention as to their place in the continuum of long-term care services.

Most board and care facility residents receive some form of public assistance, usually from the Supplemental Security Income (SSI). There are, of course, many such homes in which the residents are not dependent upon SSI or other forms of public assistance. These facilities cater to those who are able to pay privately for the services of the facilities.

Operators of the estimated 300,000 such homes often have been criticized for inadequate safety and security measures, poor care, abuse of the residents, and even financial fraud. Over the past 15 years, there have been numerous congressional hearings, GAO reports, and studies by various organizations, including a major report in 1989 by the AARP. The most recent congressional hearing was conducted in March 1989, by the Senate Special Committee on Aging, and the House Select Committee on Aging's Subcommittees on Health and Long-Term Care, and Housing and Consumer Interests. Chapter 9, Long-Term Care, provides a more detailed discussion of board and care, particularly regarding quality of care in these facilities.

(B) LIFE-CARE COMMUNITIES

Life-care communities, also called continuing care communities, typically provide housing, personal care, and nursing home care, and a range of social and recreation services as well as congregate meals. Residents enter into a contractual agreement with the community to pay an entrance fee and monthly fees in exchange for benefits and services. The contract usually remains in effect for the remainder of a resident's life. In its study on life-care, the Pension Research Council of the University of Pennsylvania developed a definition of life-care communities. It includes providing specified health care and nursing home care services at less than the full cost of such care, and as the need arises.

Estimates on the number of life-care communities range from 300 to 600, depending on the definition used. About 300 of these facilities serve at least 90,000 residents. Life-care defined in this way is viewed as a form of long-term care insurance, because communities protect residents against the future cost of specified health and nursing home care. According to the AARP, the number of life-care communities doubled in the past 10 years and is expected to continue to grow rapidly. While most life-care communities are operated by private, nonprofit organizations and some religious organizations, there has been a growing interest on the part of corporations in developing such facilities.

Some analysts view this concept as a form of long-term care insurance. Like insurance, residents who require fewer health and nursing home care services in part pay for those who require more such services. Entrance fees are usually based on actuarial and economic assumptions, such as life expectancy rates and resident turnover rates, which is also similar to insurance pricing policies.

Entrance fees range among life-care communities from approximately $40,000 to more than $150,000, with monthly fees ranging from $500 to $2,000. This wide range results from such factors as the social and health care services provided, the size and quality of independent living units, and the amount of health care coverage provided. Life-care communities do not cover acute health care needs such as doctor visits and hospitalization, and some may require residents to share in the cost of the health or long-term services they receive from the community. Studies have shown that the average age of persons entering life-care communities is 75. In independent living units, personal care units, and nursing home units the average ages are 80, 84, and 85, respectively.

Problems have been discovered in some communities, such as those using lifespan and health projections that are not actuarially sound, as well as incorrect revenue and cost projections. Some contracts are written in such a way that if a person decides, even within a reasonable period of time, that he or she does not want to stay at the facility, the entire endowment is lost and not returned, even on a pro-rated basis. Recently, there has been a growth in the number of private nonprofit corporations which sponsor life-care facilities. While the individual facility is clearly nonprofit, the corporation that organizes and develops the project is often a for-profit organization. The profitmaking goals of the developer may conflict with the financial stability of the nonprofit corporation. For example, to attract consumers and quickly raise funds, the pricing structure may be established too low to provide both profit and future financial stability.

While most life-care communities are managed effectively, some have faced financial and other problems. A growing phenomenon, life-care is just beginning to be understood and regulated. Although California, in 1939, was the first State to regulate life care, only 21 States today regulate the operation of life care communities. These States are: Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New Mexico, Oregon, Pennsylvania, Texas, Virginia, and Wisconsin. New York, which bans prepaid nursing home care, effectively prohibits life-care arrangements. There is little uniformity in the way these facilities are regulated by the States. Some States require operators to make public ownership and financial disclosures, others do not. Similarly, some States regulate resident rights and others do not. Few, if any, of the States offer adequate protection from the operator who deliberately seeks to use complex profit/nonprofit business structures and non-arms-length transactions to enhance his personal wealth at the expense of the life care residents.

Problems in some life-care communities raised concerns by many in Congress that participants be allowed to recoup entrance fees under certain circumstances. The Internal Revenue Code, however, treated refundable entrance fees as "loans" to the life-care community and imputed interest on the down payment as income received by the elderly resident. This was viewed as a hardship to life-care community residents, and in 1985 Congress enacted a proposal by Senator Heinz which exempted the first $90,000 of an entry fee from the IRS's imputed interest rules as part of Public Law 99-121.

The House version of the 1987 reconciliation bill contained a provision to repeal the exemption and reinstate the imputed tax treatment on the entire amount of a refundable entrance fee. This proposal was rejected by the conference committee and was not contained in the bill as passed (P.L. 100-202).

Supporters of life-care contend that there are a number of benefits associated with this concept. For example, the pooling of resources and risks may help to reduce the uncertainties of future costs of care, and there are greater opportunities for residents to maintain their health as health care and other services are provided on a regular basis. Others believe that while life-care is an option for some elderly, it is unlikely that many with low and moderate incomes would be able to afford it. Further, many older persons are reluctant to move from their homes and into a life-care community.

(C) SHARED HOUSING

Shared housing can be best defined as facilities housing at least two unrelated persons where at least one is over 60 years of age, and in which common living spaces are shared. It is a concept which targets single and multifamily homes and adapts them for elderly housing. Shared housing can be agency-sponsored, where 4-10 persons are housed in a dwelling, or it may be a private home/shared housing situation in which there are usually 3 or 4 residents.

The economic and seocial benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with the means to maintain these homes. In some instances, elderly who otherwise would be overhoused can help families who may be having difficulties in finding adequate housing arrangements.

According to census statistics, some 670,000 people over 65 (excluding those who are institutionalized or in nursing homes) share housing with nonrelatives; a 35 percent jump over a decade ago. In a recent AARP poll of a sampling of its 23 million members on the subject of shared housing, 15 percent said they would consider sharing living quarters with someone outside their family.

From an economic viewpoint, shared housing can be an important low-cost means of revitalizing neighborhoods. Abandoned large houses and buildings could be made suitable for shared housing with very little renovation. Dennis Day Lower, a director of the Shared Housing Resource Center in Philadelphia, has pointed out that shared housing is extremely cost effective when compared to new construction. He has noted that per unit capital costs could be 50 to 60 percent lower using shared housing.

There are various impediments to shared housing. Among the most prominent are zoning laws and reduced SSI and food stamp payments to participants. Congress has recognized and begun to act on the need to overcome them. The Housing Act of 1983 included a provision allowing the existing and moderate rehabilitation programs of Section 8 rental assistance to be used to aid elderly families in shared housing.

There are a number of shared housing projects in existence today. Anyone seeking information in establishing such a project or looking for housing in a project can contact two knowledgeable support services. One is Operation Match, which is a growing service now available in numerous communities throughout the country. It is a free public service open to anyone 18 years of age with no sex, racial or income requirements. Operation Match is a division in the housing offices of may cities. It helps match people looking for an affordable place to live with those who have space in their homes and are looking for someone to aid with their housing expenses. Some of the people helped by Operation Match are single working parents with children, those in need of short-term housing, elderly people hurt by inflation or health problems, and the handicapped who require live-in help to remain in their homes.

The other source of information in shared housing is the Shared Housing Resource Center in Philadelphia. It was founded in 1981, and acts as a link between individuals, groups, churches, and service agencies that are planning shared households.

(D) ACCESSORY APARTMENTS AND GRANNY FLATS

Accessory apartments have been accepted in communities across the Nation. These apartments were occupied by members of the homeowner's family, and, therefore, accepted into the neighborhood. Now, with affordable rental housing becoming more difficult to find, various interest groups, including the low-income elderly, are taking a closer look at this type of housing.

Accessory apartments are another form of shared housing, except that each unit has its own kitchen. As a result, this form of housing undergoes the same zoning restrictions and impediments previously mentioned in the shared housing discussion. According to one expert, about 40 percent of the single family housing stock in the country is now zoned to permit accessory apartments. According to this individual, once zoning is changed in a community, there are typically a number of applications to legalize existing accessory apartments, but very few applications for new ones. The reason is that the homeowners must deal with local government zoning and building regulations, as well as with contractors, banks, and tenants. Unfortunately, the process is intimidating for many people and it is difficult to find reliable advice. The expert suggests a basic partnership between real estate agents and remodelers to market accessory apartments.

Another innovative housing arrangement under discussion is the "granny flat" or "ECHO" flat, first constructed in Australia and recently introduced in this country. Granny flats were constructed as a means of providing housing for elderly parents or grandparents where they can be near their families while maintaining a measure of independence for both parties. In the United States, we refer to such living arrangements as ECHO units, an acronym for elder cottage housing opportunity units. ECHO units are small, freestanding, barrier free, energy efficient, and removable housing units that are installed adjacent to existing single-family houses.

Usually they are installed on the property of adult children, but can also be used to form elderly housing cluster arrangements on small tracts of land. They can be leased by nonprofit corporations or local housing authorities.

Rigid zoning laws, lack of public information, and concern about adverse changes to the neighborhood, and therefore, property values, are the major barriers to the development of ECHO housing. Many civic leaders, public officials, and organizations are reporting increased interest in the possibility of ECHO units for their jurisdictions. At this time, there is no Federal legislation dealing with this concept.

3. Prognosis

Innovative housing programs will become more and more essential in providing basic housing and support services for our Nation's elderly, handicapped, and poor. But Congress, with its full agenda of issues, particularly concerning major reform of the Federal housing role, is again unlikely to focus much attention in 1990 on innovative housing for the elderly, with the exception of board and care homes. Hearings may take place, but legislative action concerning shared housing options, life-care facilities, and other housing alternatives, will not be a high priority. It is very unlikely that legislation on these issues will be taken up by Congress, much less reach the President's desk for signature in 1990.

The life-care industry, as well as the development of other private retirement facilities, is expected to grow by leaps and bounds over the next several years, mainly appealing to the upper-middle and upper-income groups. Some are examining options for developing life-care facilities for lower income Americans, primarily those that have been able to purchase a home and have built up equity during their lifetime. This effort will evolve slowly, however, and will be undertaken primarily by nonprofit life-care interests. The for-profit life care interests will continue to expand during 1990.

As indicated, board and care will continue to receive congressional attention. Chairman Pryor and Senator Heinz are expected to continue this examination of board and care, and is likely to introduce legislation in this area. Senator Rockefeller introduced legislation—S. 1942, the Medicaid Home and Community Care Options Act—which would provide States with a new option to provide home and community-based long-term care services to low-income, frail older persons, including those with Alzheimer's disease, under the State's Medicaid program. Board and care facilities would be a site where such services could be provided. The legislation also would establish quality of care standards that would apply to Medicaid services provided in board and care facilities. In the House of Representatives, Representatives Waxman and Wyden, have introduced similar legislation, which was passed by the House as part of their 1989 budget reconciliation legislation.

Shared housing will become a more necessary option for older Americans in future years as the cost of maintaining a single residence becomes a larger burden than many elderly can afford. The need for quality board and care facilities, accessory apartments and granny flats, and other innovative approaches, will only continue to grow with the increase in the number of older Americans. In this regard, however, the role of the Federal Government will not be significant in 1990. Instead, the focus will be on reinvigorating the overall Federal role in meeting the housing needs of America's low-income citizens, and in providing ways for the disabled and those who have "aged in place" to obtain services, so that they can continue to live semi-independently.

Chapter 10

ENERGY ASSISTANCE AND WEATHERIZATION

OVERVIEW

Two Federal programs exist to ease the energy cost burden for low-income individuals. They are the Low-Income Home Energy Assistance Program (LIHEAP) and the Department of Energy's Weatherization Assistance Program. They have been severely slashed in the effort to reduce Federal budget deficits.

Although these programs have played an important role in helping millions of America's poor pay for their basic energy needs and weatherize their homes, there is a dramatic and widening gap between existing Federal resources and the needs of the population these programs were intended to serve. Fiscal year 1990 appropriations were the lowest in the programs' histories and preliminary estimates indicate a substantial drop in the number of households receiving heating assistance in fiscal year 1989 as compared with fiscal year 1988.

In fiscal year 1989, LIHEAP provided heating and energy crisis assistance, the program's largest components, to an estimated 5.9 million low-income American households, down from 6.2 million in fiscal year 1988. These households represent less than 25 percent of all households with incomes under the Federal maximum standard for the program (150 percent of poverty or 60 percent of State median income) and no more than 35 percent of all households with incomes under the stricter income standards adopted by most States which range from 110 percent of poverty to the Federal maximum standard.

The Reagan and Bush Administrations have attempted in recent years to substantially cut LIHEAP and to eliminate the DOE Weatherization Program. Since 1985, Congress has cut appropriations for LIHEAP by $707 million or 34 percent. States have responded differently to these cuts. For example, a survey of 45 LIHEAP State program administrators indicated that, for fiscal year 1988, 22 States cut heating benefits, 13 reduced the number of households served, and 18 eliminated or reduced the use of LIHEAP funds for weatherization. Twenty-six States used oil overcharge funds to supplement LIHEAP appropriations but the majority of these still had to reduce program services. The Department of Energy's Weatherization Assistance Program has been cut 20 percent since 1985.

Although Congress continued to view these programs as the Federal Government's major effort to assist low-income households with their energy costs, the perception continued to prevail that the States had substantial oil price overcharge funds available to use for funding LIHEAP. The States also continued to transfer LIHEAP funds to other block grant programs. In addition, the programs have been reduced twice under the Gramm-Rudman Act, in 1986 and 1987.

A. BACKGROUND

The radical changes in world oil markets following the 1973 embargo brought equally radical changes in the household budgets of Americans. The proportion of income required to purchase essential energy supplies rose dramatically and changes in the cost of this basic commodity brought changes in the cost of many other necessary items. Although these changes had different impacts depending on a household's income and fuel requirement, the pressure for change in consumption patterns and the erosion of real spending power due to energy inflation over the past 16 years has been unrelenting. The rising cost of energy has had a particular effect on the elderly and those with low incomes who consume relatively less energy than other households, but pay a larger portion of their disposable income for fuel.

According to Department of Energy data for fiscal year 1988, LIHEAP households spent $962 or 14 percent of their income on residential energy as compared to $1,081 or 3 percent of total income for households of all income levels. All low-income households (annual incomes under the greater of 150 percent of the poverty line or 60 percent of the State's median income) spent $939, or 11 percent of their income, on their residential energy needs. As with earlier years, data shows why the poor have a dramatic need for energy assistance programs, even though the rapid rise in energy prices has slowed in recent years.

The high cost of energy is a special problem for the low-income elderly because they are particularly susceptible to hypothermia—the potentially lethal lowering of body temperature. The Center for Environmental Physiology in Washington, DC, has reported that experts estimate that hypothermia may be the cause of death for up to 25,000 elderly people each year. The center reports that most of these deaths occur after exposure to cool indoor temperatures rather than extreme cold. In addition, the situation can worsen many pre-existing conditions and diseases in older adults, such as arthritis. Although another disease is ultimately listed as the cause of death, the center maintains that many deaths may be causally related to hypothermia.

1. The Low-Income Home Energy Assistance Program

The precursors of the current LIHEAP were a series of short term crisis intervention programs in the 1970's that were administered by the Community Service Administration (CSA) and limited to a $200 million annual appropriation. Between the winters of 1979 and 1980, the price of home heating oil doubled and Congress expanded aid sharply by creating a three-part energy assistance program at an appropriation level of $1.6 billion: $400 million to the CSA for continuation of its crisis intervention programs; $400 million to the Department of Health and Human Services (DHHS) for one-time payments to recipients of Supplemental Security

Income (SSI); and $800 million to DHHS for distribution as grants to States to provide supplemental energy allowances.

In 1980, Congress passed the Home Energy Assistance Act as part of the crude oil windfall profit tax legislation. $1.85 billion was appropriated for the program that year. The current LIHEAP is authorized by the Low-Income Home Energy Assistance Act (Title XXVI of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35)) as amended by the Human Services Reauthorization Acts of 1984 and 1986. Appropriations for fiscal year 1990 of $1.393 billion have been cut sharply from the $2.1 billion appropriated for the peak fiscal years 19885 and 1986. Appropriations in fiscal years 1987, 1988, and 1989 were $1.825 billion, $1.535 billion, and $1.385 billion, respectively.

Under the LIHEAP program, block grants are made to the 50 States, the District of Columbia, approximately 114 Indian tribes and tribal organizations and 6 U.S. territories, allocated by formulas based largely on home energy expenditures by low-income households. Financial assistance is provided to eligible households, usually directly or through vendors, for home heating and cooling costs, energy-related crisis intervention aid, and low-cost weatherization. Some States also make payments in other ways such as through vouchers or direct payments to landlords.

States also are allowed some flexibility in the use of their grants—up to 10 percent may be transferred into other block grant programs, up to 15 percent may be used for weatherization programs, and up to 15 percent may be carried over to the next fiscal year. No more than 10 percent of the grant may be used for administrative costs.

States establish their own benefit structures and eligibility rules within broad Federal guidelines. Eligibility may be granted to households receiving other forms of public assistance such as SSI, Aid to Families with Dependent Children (AFDC), food stamps, certain need-tested veterans' and survivors' payments, or those households with incomes less than 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater. Lower income eligibility requirements may be set by States and other jurisdictions, but not below 110 percent of the Federal poverty level.

Other Federal requirements include structuring benefits so households with the lowest income and highest energy costs get higher benefits, equal treatment for renters and homeowners, outreach programs to inform those potentially eligible about the program, and equitable treatment between those who are income eligible and those who are categorically eligible.

According to DHHS, States provided heating assistance to 5.6 million households in fiscal year 1989. Over 1 million households received energy crisis assistance, almost all for winter/yearround assistance rather than summer crisis assistance. Based on previous State estimates, DHHS calculates that about two-thirds of the households reported receiving winter crisis assistance also received regular heating assistance. This would make the unduplicated number of households receiving assistance with heating costs to be about 5.9 million. This compares to the 6.2 million households assisted in fiscal year 1988. In addition, 166,000 households received weatherization assistance in 1989 and a similar number received cooling assistance.

The elderly comprise the single largest group of recipients in the LIHEAP. In fiscal year 1988, the elderly comprised 35 percent of households receiving heating assistance, 61 percent of those receiving cooling assistance, 15 percent of winter crisis aid recipients, and 32 percent of those receiving weatherization aid.

According to the DHHS report to Congress for fiscal year 1988, LIHEAP benefits for heating assistance ranged from $51 and $525, averaging $217. This offset about 57 percent of the average fiscal year 1988 heating costs for recipients. Average fiscal year 1988 home heating costs for all recipient households were about $380. On average, according to DHHS, households receiving LIHEAP benefits have higher heating costs and lower income than low-income nonrecipient households.

Unfortunately, DHHS cannot estimate precisely the number of households eligible for LIHEAP. Typically, States operate LIHEAP for only part of the year and no data source provides seasonal national information on income and participation in other programs which provide categorical eligibility for LIHEAP. Further, States' procedures for determining eligibility may annualize one or more month's income to test against the income standard the State has adopted. Thus, households may be eligible for LIHEAP even though their actual annual income is above the income maximum set in law.

With these qualifications, DHHS estimates that, according to the March 1988 Current Population Survey, an estimated 24.8 million households had incomes under the Federal maximum standard and an estimated 17.9 million households had incomes under the more stringent income eligibility standards of many of the States.

2. THE DEPARTMENT OF ENERGY WEATHERIZATION ASSISTANCE PROGRAM

The DOE Weatherization Assistance Program has been authorized under the Energy Conservation and Production Act of 1976, as amended. It is designed to reduce heating and cooling costs in homes of low-income households. Although it has not been reauthorized since its authorization expired at the end of fiscal year 1985, Congress has continued appropriations for the program, although at reduced levels. The allocation for fiscal year 1990 is $161 million.

The program actually began under the Emergency Energy Services Conservation Program enacted by Congress in 1975 to provide relief to needy households by increasing the energy efficiency through insulation and repairs. By 1985, it had developed to a $191 million weatherization program. But since then, appropriations have dropped and the administration has been attempting to phase it out.

Through the program, funds are made available to States, which in turn allocate dollars to nonprofit agencies for purchasing and installing relatively low-cost materials such as insulation, storm windows, and doors. Federal law allows a maximum average expenditure of $1,600 per household. To be eligible for assistance, household income must be at or below 125 percent of the Federal poverty level. States, however, may raise their income eligibility criterion to 150 percent of the poverty level to conform to the LIHEAP income ceiling. They may not, however, set it below 125 percent of the poverty level. Also eligible for assistance are households with persons receiving AFDC, SSI, or local cash assistance payments. Priority for assistance is given to households with an elderly individual (age 60 and older) or a handicapped person. The program has served more than 1.8 million homes from the program's inception through October 1988. In 89,966 of these homes, at least one resident was 60 or older. In fiscal year 1987, 107,045 homes were weatherized and 115,120 were accomplished in fiscal year 1988.

The goals of the program include:

- —Improved energy efficiency in the homes of participants,
- —Reduced fuel bills for participants,
- —Reduced national energy consumption, and
- —Increased employment opportunities due to installing and manufacturing low-cost weatherization materials.

A DOE-sponsored evaluation of the Weatherization Assistance Program published in 1984 (based on 1981 data) showed that: [1]

- —The program reaches elderly persons in accord with its statutory priority requirement.
- —The program saves, on the average, about 13 percent of a home's heating energy. The study found that 50 percent of the weatherized homes surveyed had an energy savings of 10 percent or more; 23 percent had a savings of 20 percent or more; and 23 percent used more energy the year after weatherization.
- —Energy savings relate to the type and cost of weatherization assistance materials. Homes receiving the most extensive weatherization services (insulation plus storm windows or doors) saved more than twice as much energy as weatherized homes that were not insulated. Insulation was a key measure for producing energy savings.
- —Energy savings derived from a particular energy improvement, however, can be determined precisely only by measuring energy consumption under identical circumstances before and after the improvement is made. This condition is impossible to meet because conditions are always changing. For example, thermostat settings and energy use in a home changes from year to year.
- —More of the homes weatherized are in colder weather zones and fewer are in temperate and warm weather zones.

As a result of these findings, DOE is examinig types of occupant behavior which contribute to differences in energy savings as well as combinations of weatherization materials which optimize energy savings. A client education program relating to energy conservation behavior is also in progress.

Beginning in calendar year 1987, DOE was authorized to establish a "performance fund" from which dollars will be awarded to

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[1] U.S. Department of Energy. Energy Information Administration. Office of Energy and End Use. Weatherization Program Evaluation. SR-EEUD-84-1, Aug. 20, 1984. Executive Summary and pp. 1-2, 18-19.

States meeting its criteria for the best weatherization programs. Up to 15 percent of the amount appropriated each year for the DOE program would be used for the fund. The award criteria depends on the percentage of eligible dwelling units within a State that have been weatherized, energy savings resulting from weatherization activities, and the State's actual achievement of its Weatherization Assistance Program goals.[2] However, the program will not become operational unless $205 million or more in annual appropriations is available.

B. ISSUES

1. Evaluating Energy Assistance and Savings

Of primary concern to the Special Committee on Aging is the effectiveness of energy assistance programs in serving older persons. The elderly are particularly at risk for both hypothermia and heat stress because of physical changes associated with aging. Most elderly victims of hypothermia become ill from indoor temperatures between 50 and 60 degrees Fahrenheit. Any disease or weakness of the heart and blood vessels makes a person more vulnerable to heat stress which can cause heat exhustion, heatstroke, heart failure, and stroke.

Both LIHEAP and the Weatherization Program give priority to the elderly and handicapped citizens in assuring that these households are aware that help is available, and to minimize the danger of unnecessary shutoff of utility services. According to DHHS, about 37 percent of households receiving assistance with heating costs had at least one elderly member age 60 or over.

Although States have come up with a variety of means for implementing the targeting requirement, several aging organizations have suggested that Older Americans Act programs, especially senior centers, be utilized as information and outreach bases for the programs. Discussions with area agencies on aging and senior center staff indicate that increased effort has been made in recent years to identify eligible elderly persons for energy assistance, and to provide the elderly population in general with information about the risks of hypothermia.

A 1986 study of 13 diverse States accounting for 46 percent of the fiscal year 1985 LIHEAP appropriation and 49 percent of the Nation's low-income households, cited that all of these States reported using local organizations and aging agencies for outreach to the elderly and eligible households.

The debate over the effectiveness of LIHEAP and the DOE Weatherization Program continues. Many argue that the programs have been well directed and effective for the neediest, yet conclusive data is not available.

According to a 1986 report prepared by the Economic Opportunity Research Institute for the National Association of State Community Services Programs, frail or disabled elderly people, the very poor, and households with a history of energy shutoffs are in greater need than many households that receive energy aid. It was estimated that about 2.8 million such households, with average incomes of $2,196, are not served. Households that receive aid under LIHEAP on average have higher incomes and lower energy costs than eligible households not receiving the aid. The report stated that meeting the needs of those not currently served under LIHEAP requires more money. Using 1984 average benefits, achieving a 55-percent participation rate would require a 23-percent increase in LIHEAP funding. A much higher increase would be necessary now because of continuing budget cuts.

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[2] Federal Register. Part V. Department of Energy. Dec. 5, 1985, p. 49912.

According to the PHHS report for fiscal year 1988, low-income households expend a greater proportion of their income for space heating than do other households. The percentage of income for heating is greater still for LIHEAP recipient households. The average annual income of LIHEAP recipient households is more then 15 percent lower than the average annual income of other low-income households. Nationally, fiscal year 1988 heating costs represented about 4 percent of the average income of low-income households and 5 percent of income for LIHEAP recipient households, compared to about 1 percent of income for the average U.S. household.

The National Low Income Energy Consortium (NLIEC) issued a report in October 1988, entitled "The Late Great Energy Crisis: Hidden Hardships" which analyzed data from government and private sources. It concludes that for many Americans, "who are disproportionately poor, elderly, and infirm, energy remains as critical a concern today as it did to every American in the most ominous days of the oil embargo." The report estimated that, by 1984-85, almost one-fourth of poverty or near-poverty households spent more than 25 percent of their income on combined residential fuel expenditures. During the winter of 1986-87, the report stated that over 28 percent of all poor or near poor households suffered without heat for one or more days because their utility or fuel bill wasn't paid.

Also, according to the NLIEC report, in 42 States, 30 percent of an elderly person's maximum SSI benefits were consumed by home energy costs during the coldest months of the 1983-84 winter. In nine States, home energy costs totaled 50 or more percent of SSI benefits.

LIHEAP, however, has its critics, who generally take one of two positions. Some argue that the public welfare system, excluding LIHEAP, already is either sufficient or too generous. Another view is that assistance is needed, but not in the form provided by LIHEAP.

Those who oppose specific energy aid for low-income individuals contend that, when combined with other welfare benefits, the LIHEAP increases work disincentives, unnecessarily increases the Federal deficit, and makes the cumulative benefits under all welfare programs too generous, especially since LIHEAP benefits are not counted as income for determining eligibility and benefit levels under other means-tested assistance programs. It is also argued that LIHEAP was intended to be only a temporary emergency measure, designed to help households cope with the energy price shocks of the 1970's, and should not become part of the permanent public welfare system.

Others may favor energy-related aid for those with low-incomes, but maintain that assistance would be provided more efficiently through the more established means-tested programs such as AFDC, SSI, or food stamps. However, this would exclude the currently estimated 30 percent of LIHEAP recipients who are nonwelfare poor, such as the elderly and working poor.

Others argue that LIHEAP, by increasing household income available for energy, discourages energy conservation. The twin goals of helping low-income households meet high energy costs and encouraging energy conservation would be better achieved, some assert, through home weatherization or renewable energy home improvements.

Various studies have attempted to quantify energy savings from Federal weatherization efforts. According to the GAO, it is difficult to measure such savings due to differing conditions of dwelling units and varying climatic conditions and fuel prices throughout the country. Additionally, little or no effort has been made to verify the accuracy of fuel-use records in homes that have been weatherized. Experts in this area have noted that most studies do not use control groups where fuel costs in homes weatherized are compared with fuel costs in homes not weatherized. Lacking a control group, it is difficult to accurately predict whether changes in energy consumption are due entirely to weatherization assistance or to changes in fuel prices, conservation programs, appeals from political leaders, or a combination of these. Further, it has been observed by program personnel that some households may conserve less after weatherization because they raise their thermostats to a more comfortable level.

According to GAO, the extent to which DOE's program is reducing energy costs and consumption is unknown by DOE and the States that administer the DOE program. While DOE has claimed a 20-25 percent annual energy savings in homes weatherized through its program, GAO reports that this statistic has questionable reliability because of DOE's sampling and data problems.[3]

A study conducted in the State of Minnesota of its weatherization program employed a more scientific methodology to evaluate energy savings. Based on an analysis of fuel records from both weatherized and nonweatherized homes, the study concluded that the DOE program was successful in reducing energy consumption by an average of 13 percent. The study also concluded that the cost of weatherization is likely to be repaid within 3½ years through lower fuel bills.[4]

Although this evaluation initially showed promise for a careful examination of energy savings, the GAO reported that the study was too geographically limited to reveal savings on a nationwide basis. In the final analysis, GAO has concluded that there is no nationwide study on cost savings that incorporates standardized statistical methods in a way to assure maximum reliability. However, the evaluation discussed earlier in this chapter under the DOE Weatherization Program description was conducted after GAO's analysis, and provides evidence that the program is working. A number of States have also conducted studies since that time and many show energy savings in the 14-25 percent range.

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[3] U.S. Government Accounting Office. Uncertain Quality, Energy, Savings and Future Production Hamper the Weatherization Program; Report to the Congress by the Comptroller General of the United States. EMB 82-2. Oct. 26, 1982. Washington, 1982, pp. 18-20.

[4] Hirst, Eric and Raj Talwar. "Reducing Energy Consumption in Low Income Homes." Evaluation of the Weatherization Program in Minnesota. Evaluation Review, V.5, October 1981, pp. 671-683.

2. Block Grant Versus Categorical Funding

Another issue concerns funding Federal weatherization programs through block grants versus categorical grants. Many public officials agree that the Federal Government should support weatherization activities for low-income households. The nature of this support, however, has been somewhat controversial. While some groups favor the block grant approach to Federal assistance, others find more merit in the categorical grant approach of the DOE program. At the State and local levels, however, the two programs often have the same or similar guidelines and often are administered by the same agencies.

States have statutory authority to transfer to LIHEAP up to 10 percent of their social services block grant allotments and up to 5 percent of their community services block grant allotments, although, no State has done so. On the other hand, the LIHEAP statute provides that a State may transfer up to 10 percent of the LIHEAP funds payable to it for a fiscal year for use in one or more of the six other block grants administered by DHHS. Twenty-nine States transferred a total of approximately $54 million of LIHEAP funds to these block grants in fiscal year 1989, substantially less than in earlier years. Twenty-six of these States transferred funds to the social services block grant.

C. LEGISLATION

Despite efforts by the Reagan and Bush Administrations to reduce Federal funding for the LIHEAP (assuming petroleum overcharge funds would make up the difference) and to eliminate or phase-out the Department of Energy Weatherization Program, Congress has only grudgingly reduced appropriation levels.

1. Low-Income Home Energy Assistance Program

The current LIHEAP is authorized by the Low-Income Home Energy Assistance Act (Title XXVI of the Omnibus Budget Reconciliation Act of 1981: P.L. 97-35), as amended by the Human Services Reauthorization Acts of 1984 and 1986 (P.L. 98-558 and P.L. 99-425). The 1986 amendments reauthorized appropriations through fiscal year 1990 at gradually increasing levels of $2.05 billion for fiscal year 1987 to $2.307 billion for fiscal year 1990.

(A) 1986 REAUTHORIZATION OF LIHEAP

(1) Reauthorization

In 1986, to extend the authorization of LIHEAP appropriations, the administration submitted draft legislation that proposed to:

(1) Extend the appropriations authorization for 3 years at $2.1 billion for fiscal year 1987 and with no specific authorization levels for later years,

(2) Remove the 15-percent limit on the proportion of a State's allotment that may be devoted to weatherization assistance,

(3) Repeal the requirement that States describe home energy usage within each State in their annual application for an allotment,

(4) Require States to take into account other assistance available to LIHEAP beneficiaries when establishing their LIHEAP benefits,

(5) Revise the method of calculating and providing special LIHEAP grants to Indian tribes, and

(6) Change certain nondiscrimination provisions of LIHEAP law.

However, Congress chose to design reauthorization legislation that, in effect, ignored many of the administration's recommendations.

In September 1986, House-Senate conferees on H.R. 3321 agreed on the 1986 reauthorization of LIHEAP (P.L. 99-425). It included the following provisions:

(1) A 4-years reauthorization of appropriations for LIHEAP with authorization levels increasing 4 percent a year:

	Billion
Fiscal year 1987	$2.050
Fiscal year 1988	2.132
Fiscal year 1989	2.218
Fiscal year 1990	2.307

(2) Provisions stipulating time deadlines that must be met in delivering energy crisis aid and making it clear that community-based organizations such as community action agencies may be designated to administer energy crisis intervention programs.

(3) Revisions in the method of calculating and providing special LIHEAP grants to Indian tribes.

(4) Provisions emphasizing the requirement that States adjust benefits to ensure that the neediest households receive the maximum assistance.

(5) Provisions reorganizing State plan requirements and directing the development of a model State plan.

(6) A requirement for an annual report on LIHEAP.

(7) Provisions stipulating that receipt of LIHEAP benefits do not affect eligibility or benefits under the Food Stamp Program. (See Food Stamp chapter for details.)

(B) CURRENT FUNDING LIHEAP

Appropriations for fiscal year 1990 of $1.393 billion are sharply lower than the $2.1 billion in the peak fiscal years 1985 and 1986. Congress approved this level as a compromise between the House funding level of $1.4 billion and the Senate level of $1.279 billion. The administration had asked for $1.2 billion. In fiscal year 1989, the appropriation was $1.385 billion.

Not all the $1.393 billion appropriated in fiscal year 1990 will be available to States immediately. About $60 million will be held back until the very end of the fiscal year.

This year, as in recent years, Congress' legislative focus has been on the appropriations level, rather than the structure of the program. In setting appropriations, the main issue has been the extent to which States have access to and use "oil price overcharge" money to help fund LIHEAP.

From 1973 to 1981, the United States imposed price controls on crude oil and petroleum products in response to the Arab oil embargo. Since then, a number of lawsuits have been filed against certain oil companies for alleged overcharges during that period.

Money recovered from oil companies in two recent major court decisions for oil price overhcarges under the Emergency Petroleum Allocation Act of 1973 (P.L. 93-159) has been made available to the States as possible additional funding for LIHEAP and other energy-related programs. The courts stipulated a restitutionary principle oringinally adopted by Congress which requires that these funds be used to "supplement, not supplant" existing Federal and State resources. Each State decides how it will allocate the funds.

The first national distribution of oil overcharge funds was a $200 million settlement referred to as Warner amendment funds, named after the Senate sponsor of the legislation (section 15 of P.L. 97-377). Held in escrow by the Energy Department, the funds were allocated to the States in early 1983 according to each State's share of the national usage of petroleum products during the period of the oil price overcharges involved in the court settlement.

Under the 1985 $2.1 billion *Exxon* decision, the Department of Energy also allocated the award to the States according to their use of petroleum products. States were to use the funds for LIHEAP and four other programs. These programs were the Low-Income Weatherization Program, the Schools and Hospitals Weatherization Program, the State Energy Conservation Program, and the Energy Extension Service. All of these programs, except LIHEAP, are administered by the DOE. States may use their allocations over a period of years. DOE, through its Office of Hearings and Appeals, also is requiring the States to spend their overcharge funds in a "balanced" manner.

The other case, the Stripper Well decision, is projected to yield a total of $4 to $5 billion of which $2 to $2½ billion goes to the States. Almost $1 billion has been allocated the States through fiscal year 1988 and the rest will be distributed over the next 5 to 10 years. These funds may be used for LIHEAP and the other four energy conservation programs as well as a broader range of energy programs. In addition, States are required to spend "an equitable share" on low-income programs.

Since 1981, more than $3.5 billion has been provided to the States in recouped funds, nearly all of it distributed in 1986. According to a November 1988, report by the National Consumer Law Center, the States have allocated 93.3 percent or $2.83 billion of the total $3.04 billion of Exxon and Stripper Well funds which they have received from 1986 through August 1988. Of the combined funds, 44 percent was allocated for low-income uses, 20 percent has been designated for LIHEAP, including weatherization, and 20 percent for the Department of Energy Weatherization Program. Another 3.4 percent has been allocated to other low-income programs such as weatherizing public housing and homeless shelters and transportation for the poor and elderly. Most States have decided to allocate the actual spending of the overcharge funds over a number of years.

Data from the DHHS indicate that appropriation cuts were clearly not supplanted by oil overcharge funds. Since the beginning of oil price overcharge distributions to the States, DHHS estimates that less than $500 million has been designated by the States for support of LIHEAP. On the other hand, annual appropriations for LIHEAP are more than $600 million a year less than in 1985. Preliminary telephone survey estimates by DHHS indicate the States used about $170 million of oil overcharge money for LIHEAP in fiscal year 1989.

Most recently, a 1986 Federal district court ruling approved a settlement in the so-called "Stripper Well" case. The first and largest distribution was $753 million. Another $49 million in Diamond Shamrock overcharge funds were disbursed by DOE in 1986 and a disbursement of about $90 million of Stripper Well funds went to the States in 1987.

Although the settlement potentially involved a total of $2 to $2½ billion, $500 million was designated to be paid to major fuel users (airlines, railroads, etc.) and the balance of the settlement will be split evenly between the States and the Federal Government.

One of the larger cases, with the Texaco Corp., was settled in August 1988. Under the agreement, Texaco is to pay a total of $1.25 billion over 5½ years. The first payment of about $348 million may be made during the winter of 1989 with at least $90 million going to the States. The next payment, of $190 million plus interest, will occur 18 months later followed by four annual payments of $165 million plus interest.

The availability of money from recouped oil overcharges has become an issue with regard to LIHEAP. To the extent that States have access to this money and use it to fund LIHEAP efforts, it is argued that Federal appropriations can be frozen or reduced. Indeed, the Senate reduced appropriations for both fiscal years 1987 and 1988 in recognition of overcharges. Rather than reduce Federal appropriations, some argue that any Federal share of the recouped overcharges should be earmarked to fund LIHEAP.

Those who disagree with these positions argue that the availability of oil overcharge funds should not affect appropriations for LIHEAP or the Low-Income Weatherization Program. They state that oil overcharge funds are neither Federal nor State funds, but represent lost resources by purchases across the country as a result of illegal action. Since they are intended to remedy past injuries, they should be applied in a way that addresses those past injuries and should not be used to replace current funds in on-going Federal programs. They also argue that through the Warner amendment, congressional intent, reinforced by the courts, made the oil overcharge money available to the States to be used in addition to (not instead of) existing Federal and State money for five designated Federal programs.

In addition, many States have spent a larger amount of their overcharge funds on weatherization program, arguing that these are long-term investments that reduce the money for energy assistance. Many State legislatures also have allocated the overcharge funding and could not reconvene in time to appropriate for the 1988 winter after Congress made the final decision for significant cuts in the LIHEAP appropriations in 1987.

According to an April 1988 GAO report, 7 of the 13 States reviewed had little or no oil overcharge funds remaining. The average cuts in LIHEAP allotments was 41 percent for fiscal years 1986 through 1989 for all 13 States. The average oil funds available were 13 percent less than the Federal funding reduction.

As more oil price overcharge funds become available to the States, it is uncertain what effect the availability of this recouped money will continue to have on Federal appropriations over the long term and on State support for LIHEAP beyond Federal allotments of LIHEAP funds.

(C) WEATHERIZATION

In his fiscal year 1986 budget request to Congress, the President recommended a $152.9 million funding level for the DOE Weatherization Program with a plan to phase out the program over a 5-year period. The President also recommended helping States develop strategies for conducting weatherization activities without Federal assistance during the phaseout period. In response to this recommendation, DOE began to help States with techniques for carrying out weatherization activities without Federal funds and awarded 38 "opportunity grants" ranging from $40,000 to $60,000 each to State and local agencies for demonstrating strategies to weatherize homes without Federal funds.

For fiscal years 1987, 1988, and 1989, the President proposed phasing out Federal assistance for the Department of Energy Weatherization Assistance Program in future years and funding was proposed to come from settlement of petroleum pricing violation cases.

Congress, however, has not acted on the President's request to phase out the program. The program operated at a level of $161 million in fiscal year 1987 and had the same allocation for fiscal years 1988, 1989, and 1990.

D. PROGNOSIS

There is clear evidence that Federal energy assistance programs have been successful in providing emergency relief and basic energy needs to millions of elderly and poor Americans. These programs have also reduced the energy expenditures for many of the poor through weatherization assistance. The level of support for the programs and their philosophical appropriateness, however, continue to be debated.

Nonetheless, the energy expenses of the elderly and poor will continue to grow during the next decade, creating a wide gap between their needs and the Federal Government's response. According to the Community Action Foundation (CAF) 4 million households had utility service terminated for nonpayment in 1982. To prevent service terminations from increasing and to keep the percentage of real income devoted to energy by the poor at a manageable level, billions of dollars in assistance will be needed. CAF estimated that if energy costs grew 2 percent per year, the eligible population would have needed $7.3 billion in 1989, just to maintain its purchasing power.

The Alliance to Save Energy had demonstrated that cost-effective low-income conservation programs are possible through installation of new heating system technologies. The development and field testing of much of the new heating system technologies was supported through Federal research and development efforts. Funding for these research activities has been decreasing in recent years, even though these investments in research could result in saving elderly households millions of dollars in energy costs. Along with support by the weatherization component of LIHEAP and the Weatherization Assistance Program, the availability of research funds will play an important role in determining future conservation successes.

In the past few years, many gas and electric utilities have been required by State public utility commissions to undertake low-income and elderly conservation programs. These programs could have a positive effect on the energy needs of the elderly. This approach encourages greater State and local control and funding of such conservation activities.

The main issues facing Congress in 1990 will be the proper appropriations level for these programs and the reauthorization of the LIHEAP program. The Bush Administration is likely again to propose cuts in program funding levels, justifying its action by assuming oil overcharge funds will be available. Given such an administration proposal and the current mood in Congress, appropriations at levels to more fully meet the needs of the poor and elderly will probably not be forthcoming. Continued congressional support and expanded public pressure will be needed to prevent further appropriations cuts.

The current authorization for the LIHEAP program expires in 1990, requiring Congress to debate reauthorization for 1991 and beyond. The main issues will be the level of authorized funding, the formula by which funds are distributed to States, and whether States will continue to be allowed to transfer LIHEAP funds to other programs. Although the program has been authorized for funding well above $2 billion a year for years, actual appropriations have fallen far below authorized levels. In 1984, Congress established a new, more finely tuned formula to distribute funds to the States, basing it on low-income households energy costs and expenditures. The new formula was to "kick in" when appropriations were above $1.975 billion. State shares of funding below that amount hinge on their share of 1981 funding. Because appropriations have been declining rather than rising, the new formula has not had a chance to be applied. States which would benefit under the allocation formula may push for its reconsideration. A formula battle is likely to be a focus of congressional attention, with each State delegation considering the immediate impact of differing proposals.

The greatest roadblock to increased funding for LIHEAP remains the perception in Congress that oil overcharge funds will continue to be available to States for use in LIHEAP and weatherization programs, and that States transfer too much to other nonenergy programs. The amount that States will receive from future oil overcharge cases is uncertain; however, it is apparent that they will not receive another large distribution like the Exxon and Stripper Well disbursements in 1986 and future, smaller distributions will be made in a series over a number of years. Another variable is the weather. These questions aside, what is clear is that millions of eligible families will continue to be underserved.

Chapter 11

OLDER AMERICANS ACT

OVERVIEW

For the past 25 years, the Older Americans Act (OAA) (the Act) has served as the cornerstone of Federal involvement in a wide array of community services to older persons. Created during a time of rising societal concern for the needs of the poor, the Act marked the beginning of a categorical approach to programs specifically designed to meet the social and human needs of the elderly. The Act itself was one of a series of Federal initiatives that were part of President Johnson's Great Society programs. These legislative initiatives grew out of a concern for the large percentage of older Americans who were impoverished, and a belief that greater Federal involvement was needed beyond the health and income-transfer programs. Although older persons could receive services under a number of other Federal programs, the Act became the first major vehicle for the organization and delivery of community-based social services to older persons.

The OAA followed on the heels of a similar but somewhat more expansive grouping of social service programs initiated under the Economic Opportunity Act of 1964. With a conceptual framework similar to that embodied in the Economic Opportunity Act, the OAA was established on the premise that decentralization of authority and the use of local control over policy and program decisions would create a more responsive service system at the community level.

When enacted in 1965, the Act established a series of broad policy objectives designed to meet the needs of older persons. these objectives, however, lacked both legislative authority and adequate funding. The Act, however, established a structure through which the Congress would later expand aging services.

Over the years, the essential mission of the Act has remained very much the same: To provide a wide array of social and community services to those older persons in the greatest economic and social need in order to foster maximum independence. The key philosophy of the program has been to help maintain and support older persons in their homes and communities to avoid unnecessary and costly institutionalization. Some of the services supported under the Act include congregate and home-delivered meals, senior centers and nursing home ombudsman activities, and community service employment programs.

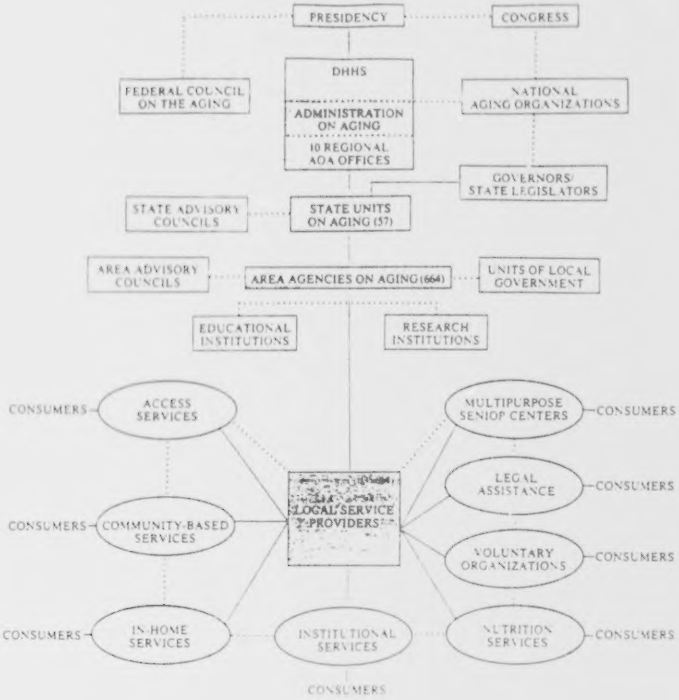
Funding for the OAA grew slowly during the 1960's, but during the 1970's Congress followed up on improvements in income-transfer programs with significant modifications to the Act by broaden-ing the scope of operations and establishing the basis for a "network" on aging under the Title III program umbrella. In 1972, a national nutrition program for older Americans was created. Area agencies on aging (AAAs), authorized by legislation enacted in 1973 along with the State units on aging, constitute the administrative structure for programs under the Act. In addition to funding specific services, they have broad responsibilities to act as advocates on behalf of older persons and to plan for the effective development of a service system that will best meet these needs. As originally conceived by the Congress, this system was meant to encompass both services funded under the Act, and services supported by older Federal, State, and local programs. The purpose of the community service employment program is to subsidize part-time community service jobs for unemployed persons aged 55 and over who have low incomes. The program, administered by the Department of Labor, awards funds to national organizations and to State agencies to operate the program.

Fiscal years 1978 and 1981 saw further improvements in the level of financial support directed toward Older Americans Act programs, continuing development of the structures for providing community-based services (AAAs) and the added emphasis on the provisions of certain priority services, such as access (transportation, outreach, and information and referral), in-home and legal services.

This expansion trend continued until the early 1980's when, in response to the Reagan Administration's policies to cut the size and scope of many Federal programs, the growth of OAA spending was slowed substantially, and for some programs was reversed. For example, between fiscal years 1981 and 1982, Title IV funding for training, research, and discretionary programs in aging were cut by approximately 50 percent. However, widespread congressional support for other OAA programs, especially nutrition and senior employment, served to protect them. This broad congressional support for OAA programs continued during the 1987 reauthorization of the Act and can be expected to continue in the future, including the impending 1991 reauthorization.

Chart 1

OLDER AMERICANS ACT NETWORK


PRESIDENCY
CONGRESS
DHHS
FEDERAL COUNCIL ON THE AGING
NATIONAL AGING ORGANIZATIONS
ADMINISTRATION ON AGING
10 REGIONAL AOA OFFICES
GOVERNORS/ STATE LEGISLATORS
STATE ADVISORY COUNCILS
STATE UNITS ON AGING (57)
AREA ADVISORY COUNCILS
AREA AGENCIES ON AGING (664)
UNITS OF LOCAL GOVERNMENT
EDUCATIONAL INSTITUTIONS
RESEARCH INSTITUTIONS
CONSUMERS
ACCESS SERVICES
MULTIPURPOSE SENIOR CENTERS
CONSUMERS
LEGAL ASSISTANCE
CONSUMERS
CONSUMERS
COMMUNITY-BASED SERVICES
LOCAL SERVICE PROVIDERS
VOLUNTARY ORGANIZATIONS
CONSUMERS
CONSUMERS
IN-HOME SERVICES
INSTITUTIONAL SERVICES
NUTRITION SERVICES
CONSUMERS
CONSUMERS

SOURCE: National Association of State Units on Aging

A. THE OLDER AMERICANS ACT AMENDMENTS OF 1987 [1]

The following is a brief description of each title of the Older Americans Act of 1965 and the key provisions added by the Older Americans Act Amendments of 1987:

1. Title I—Declaration of Objectives

Title I outlines broad social policy objectives aimed at improving the lives of all older Americans in a variety of areas such as income, health, housing, and long-term care. The amendments added an additional objective, the protection of the elderly from abuse, neglect, and exploitation.

2. Title II—Administration on Aging

Title II establishes the Administration on Aging (AoA) to administer most Older Americans Act programs and to act as the chief Federal agency advocate for older persons. It also establishes the Federal Council on Aging to advise the President and Congress regarding the needs of older persons.

The issue of the organizational status of the AoA has been a recurring one during previous OAA reauthorizations due to concern that AoA, because it is located within the Office of Human Development Services, does not have the visibility to effectively advocate on behalf of the elderly on a broad range of issues. The 1987 amendments addressed this concern by elevating the status of the Commissioner within the Department of Health and Human Services. The Commissioner now will report directly to the Secretary, as compared to the prior law provision which required the Commissioner to report to the "Office of the Secretary."

The Commissioner is also required to establish within AoA a new Office for American Indian, Alaskan Native, and Native Hawaiian Programs to be headed by an Associate Commissioner. In addition, the amendments added a number of new provisions requiring increased data collection by AoA.

The amendments increased from six to nine the number of older persons who serve on the Federal Council on Aging. The Council also is to have representation from Indian tribes.

3. Title III—Grants for State and Community Programs on Aging

Title III establishes authority for the network of State and area agencies on aging and requires the development of a comprehensive and coordinated services system for older persons.

Under prior law, Title III contained three parts authorizing funds to State agencies on aging for supportive services (part B), congregate nutrition services (part C-1), and home-delivered nutrition services (part C-2). Although the 1987 OAA amendments made certain changes relating to the administration of these services by

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[1] For a more detailed description of the 1987 Older Americans Act Amendments, see U.S. Senate Special Committee on Aging Committee Print 100-C and U.S. House Select Committee on Aging Committee Print 100-683.

State and area agencies on aging, the major amendments included a number of new authorizations of funds for a number of programs.

These programs' areas are:

Nonmedical in-home services for the frail elderly under a new part D,

Services to meet the special needs of the elderly under a new part E,

Health education and promotion activities under a new part F,

Elder abuse prevention activities under a new part G,

Long-term care ombudsman services and,

Outreach services to older persons potentially eligible for Supplemental Security Income, Medicaid, and Food Stamp Programs.

While State and area agencies have had responsibilities in these areas under prior law, separate authorizations of Title III funds were not specified. Except for in-home services for the frail elderly, the amendments include a funding trigger that prohibits appropriations of funds for the new authorizations unless total appropriations for programs in effect in fiscal year 1987 increase by at least 5 percent. These funding restrictions are in effect through fiscal year 1990.

Under prior law, each area agency on aging was to provide assurances that it would spend an "adequate proportion" of its allotted funds for supportive services on three categories considered as priorities under the area plan. These are (1) access services (transportation, outreach and information, and referral), (2) in-home services (homemaker and home health aide, visiting and telephone reassurance, chore maintenance, and supportive services for families of elderly victims of Alzheimer's and related diseases), and (3) legal assistance. The 1987 amendments changed this requirement to stipulate that each State agency is to set a minimum percentage of funds to be used for these three service categories by each area agency.

Several amendments require the coordination of Title III services on behalf of specific groups of older individuals. Various provisions focus on the needs of persons with mental illness, victims of Alzheimer's disease and their families, persons with disabilities, and those in need of community-based long-term-care services.

Other new Title III provisions require State and area agencies on aging to focus on the needs of older Indians, including requirements that the distribution of this group be considered when planning services with the State and the planning and service area. The law also added a new provision requiring area agencies to conduct outreach activities to identify older Indians and inform them of services under the Act if their population is significant within the planning and service area. Finally, other provisions were added to clarify the eligibility of Indians to receive services under both Title III and the Title IV grant programs.

4. TITLE IV—TRAINING, RESEARCH AND DISCRETIONARY PROJECTS AND PROGRAMS

The Title IV program authorizes the Commissioner to award funds for a broad array of training, research, and demonstration programs in the field of aging.

The 1987 amendments added several new demonstration authorities, including areas related to health education and promotion, volunteerism, coordination of the long-term care ombudsman program with protection and advocacy systems for the disabled, and consumer protection activities in long-term care. For the latter two, the amendments authorized separate funding amounts distinct from the overall Title IV funding. The funding of long-term care gerontology centers was made mandatory. These centers previously were supported at the discretion of the Commissioner.

5. TITLE V—COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

The Community Service Employment Program authorizes funds to subsidize part-time community service jobs for unemployed, low-income persons 55 years of age or older. Funds are awarded to eight national organizations and to State agencies. Enrollees are paid at the Federal or State minimum wage or the local prevailing rate of pay for similar employment.

The 1987 amendments set the allowable administrative cap for the program at 13.5 percent, but retained a prior provision allowing the Secretary of Labor to raise the cap to 15 percent. Also, a new provision was added to exclude Title V wages received by enrollees from consideration when determining eligibility for Federal housing and Food Stamp Programs. In addition, the Secretary of Labor and Title V grantees are required to distribute information to help program participants identify age discrimination and understand their rights under the Age Discrimination in Employment Act. Finally, some Title V funds are to be reserved for national Indian aging organizations and national Pacific Island and Asian American aging organizations in the first fiscal year in which Title V appropriations exceed the fiscal year 1987 level. Appropriations for fiscal year 1989 exceeded the 1987 level. The Department of Labor will make funds available to the additional national organizations on July 1, 1989.

6. TITLE VI—GRANTS FOR NATIVE AMERICANS

Prior to the enactment of the Older Americans Act Amendments of 1987, Title VI of the Act authorized funds for grants to Indian tribes for supportive and nutrition services that are comparable to those provided under Title III. The amendments expanded the title to include a new part B authorizing funds for Native Hawaiians.

The 1987 amendments included two changes to prior law provisions on eligibility of Native Americans for Title VI services. The first provision amended the law to make a tribal organization eligible for Title VI funds if it has at least 50 older Indians, as compared with the prior provision which specified that tribal organizations must have at least 60 older Indians to receive funds. Second, the amendments eliminated prior law provisions prohibiting individuals or tribal organizations receiving services or funds under Title VI from also benefiting from the Title III program. As amended, the law now allows older Indians to receive assistance under both the Title VI and Title III programs.

The amendments added a new part B, the Native Hawaiian Program, and specified separate authorizations of appropriations for it within the overall authorization amount for Title VI.

7. OTHER PROVISIONS

(A) REPEAL OF TITLE II

Title VII, Older Americans Personal Health Education and Training Program, added to the Act in 1984, has never received an appropriation and was repealed by the 1987 amendments. However, an amendment was added to Title IV to preserve its intent. That provision authorizes the Commissioner to commit funds to institutions of higher education to develop prototype health education and promotion programs to be used by the network on aging.

(B) 1991 WHITE HOUSE CONFERENCE ON AGING

The 1987 amendments authorized the President to call a White House Conference on Aging in 1991 (a) to increase public awareness of the contributions of older individuals to society, (b) to identify problems as well as the well-being of older individuals, (c) to develop recommendations for the coordination of Federal policy with State and local needs, (d) to propose specific and comprehensive recommendations for both executive and legislative action to maintain and improve the well-being of older individuals and (e) to review the status of recommendations adopted at previous White House Conferences on Aging.

The conference will bring together representatives of Federal, State, and local governments, persons working in the field of aging, and the general public, particularly older persons. The new provisions also set forth requirements regarding delegate selection, committee composition, conference agenda, and reporting requirements.

(C) CONSUMER PRICE INDEX FOR OLDER AMERICANS

The Secretary of Labor was required to develop an index of consumer prices to reflect the consumption expenditures of persons 62 years of age or older. This index and a report on the research necessary to develop and accurately measure the rate of inflation for older persons was provided to Congress in June 1988.

(D) AMENDMENT TO THE NATIONAL SCHOOL LUNCH ACT

The National School Lunch Act was amended to permit adult day care centers to receive reimbursement under the Child Care Food Program for meals or meal supplements (snacks) to persons 60 years or older or to chronically impaired disabled persons.

B. ISSUES

1. Cost-Sharing

During the 1987 reauthorization hearings, the administration's proposals included a provision which would authorize States, at their option, to permit area agencies on aging to charge fees, based on beneficiaries' ability to pay, for supportive services under part B of Title III. Under this proposal, States could choose which supportive services would be subject to charges.

Organizations representing States and area agencies on aging submitted their own proposal for amendments to allow State agencies on aging to establish procedures for either voluntary or mandatory cost-sharing for selected services under Title III and allow area agencies on aging to solicit voluntary contributions. The State and local levels of the aging network are increasingly pressed to find alternative sources of funding to supplement the limited availability of Federal funding and continue to provide needed services. In addition, the State and area agencies, in advocating the cost-sharing proposal, believed that a sliding fee scale would allow coordination of OAA program services with other services that are means-tested in some way. It was argued that cost-sharing would permit an increased level of services without increasing Federal funding, and could be structured to increase services to those most in need, thus increasing low-income and minority participation in Title III programs. Some services, such as referral, outreach, advocacy, and ombudsman services, were to be exempt as well as those persons who had incomes of less than 125 percent of the poverty level.

This latter proposal, which drew sharp opposition, later was amended to request that a limited number of States be given authority to conduct studies on cost-sharing in the programs under the Older Americans Act. Cost-sharing or fee-for-service, however, is viewed by many in Congress as either a preliminary step to or a pseudonym for means-testing. There was concern that cost-sharing would produce an unintended opposite effect causing participation of the neediest individuals to decline due to either a misunderstanding of the cost-sharing requirements or an unwillingness to disclose financial information.

Because the OAA was intended to be the major vehicle for the organization and delivery of community-based services to all older Americans regardless of income, Congress has consistently rejected any attempts to introduce means-testing and did so again during the 1987 reauthorization. However, the Senate Committee on Labor and Human Resources requested the General Accounting Office to study current State cost-sharing systems. In October 1989, GAO issued a report on cost-sharing that found: (1) cost-sharing is used for in-home services in at least 36 States; (2) the services commonly subject to cost-sharing were adult day care, home health care, and personal services; (3) the majority of State and areas agencies on aging that were surveyed by GAO supported cost-sharing, principally because it permitted them to serve greater numbers of clients and to offer a broader range of services; (4) self-reported income was the most commonly used determinant for establishing cost-sharing fees; and (5) cost-sharing fees, in the three States GAO examined closely, were generally a small percentage of client incomes and service costs.

2. Targeting

Another major issue during the 1987 reauthorization process was how to improve targeting and outreach to certain subgroups of older persons, particularly low-income minority persons. Although the Act has required that State and area agencies on aging are to give preference to the elderly with the greatest economic or social need, with particular attention to low-income minority individuals, many advocates stressed it should be specified in all relevant sections of the law to ensure that the preference actually was achieved.

The reauthorization hearings documented that participation by minorities in Title III programs had declined by a disturbing 27 percent since 1981. Reasons cited for the decline included that minority persons often felt that OAA programs were not responsive to their needs and priorities, meals were not culturally appropriate, non-English publications seldom were available, and there was insufficient publicity about OAA programs and referral services. Additional reasons given were that outreach to minority older persons by areas agencies on aging was poor and that minorities were absent or excluded from the service delivery planning process on local advisory councils.

In response to these concerns, the 1987 OAA reauthorization incorporated a number of provisions designed to strengthen prior law requirements with respect to planning and service delivery for elderly minority persons. These provisions include requirements that State and area plans on aging identify the number of low-income and minority older persons in the State or planning and service area, and describe methods used to meet their needs in the previous year. Another new provision to address this issue requires service providers to specify how they will meet the needs of low-income minority older persons and to attempt to provide services to such individuals in at least the same proportion as they respresent the total older population in the area.

President Reagan, in signing the 1987 amendments into law, expressed his opposition to these changes by questioning the constitutionality of the targeting provisions.

As a result of the 1987 amendments, the question of how to target services to these in greatest economic and social need, with particular attention to low-income minority individuals, without use of a means test to determine eligibility was a frequent topic of discussion within the aging network during 1988. The Federal Council on Aging devoted one of its quarterly meetings to the issue.

3. Organizational Status of the Administration on aging

One of the perennial issues under the OAA has been the organizational status of the Administration on Aging (AoA). Even before the creation of AoA as part of the Older Americans Act in 1965, the appropriate placement of an agency to oversee aging issues within the Federal framework was debated. The original sponsors of the legislation conceived of placing such an agency at the White House level so it would not be subordinate to any one agency or department; rather, it would be an independent agency able to carry out broad interdepartmental functions. This placement, however, was strongly opposed by officials of the Executive branch. Therefore, the sponsors turned to a compromise position to expedite passage of the Act. Under the 1965 legislation, AoA was placed within the then Department of Health, Education, and Welfare (DHEW) and did not have independent status. However, over the years, many policymakers have questioned whether AoA could carry out its interdepartmental functions and serve as a Federal coordinator and advocate for the elderly as well as influence Federal programs and policies from its positions within a Federal department.

The 1973 amendments placed AoA within the Office of the Secretary of DHEW, made the Commissioner of AoA directly responsibile to that Office and prohibited any delegation of the Commissioner's functions to any other officer not directly responsible to the Commissioner. When the Office of Human Development Services (OHDS) was subsequently created as part of the Office of the Secretary, AoA was placed as a separate unit within that office as part of an Executive branch reorganization. During consideration of the 1978 amendments, discussion concerning the appropriate placement of AoA ranged from making it an independent office at the White House level to retaining the agency in the current position. The amendments, however, did not change prior law, thereby retaining the agency within OHDS.

Discussion about the proper placement of AoA and the Commissioner on Aging again occurred during the 1981 reauthorization process. However, despite airing of the issue, Congress did not change AoA's status. Again in 1984, discussion developed around AoA's organizational placement. Although the House-passed reauthorization bill provided for an Office on Aging to be headed by a Commissioner on Aging reporting directly to the Secretary of Health and Human Services, the Conference agreement retained the pre-existing placement of AoA, but amended the law to emphasize a direct reporting relationship between the Commissioner and the Office of the Secretary of DHHS.

In 1987, Congress further clarified the issue of AoA's organizational status and reporting relationship with the Secretary by elevating the AoA to the same level of authority as assistant secretaries and other commissioners within the Department. Congress amended the law to require that the Commissioner report directly to the Secretary rather than to the Office of the Secretary.

The organizational status of AoA was addressed during an oversight hearing by the Senate Labor and Human Resources Aging Subcommittee on May 18, 1989. At that hearing, Kevin Moley, Assistant Secretary of Management and Budget of DHHS, testified that the Commissioner on Aging reports directly to Secretary Sullivan "on programmatic and policy issues," although AoA continues to "receive administrative and logistical support from the Office of Human Development Services" within DHHS.

C. FEDERAL RESPONSE

1. OLDER AMERICANS ACT AUTHORIZATION

The 1987 amendments to the OAA (P.L. 100-175) provided for the following authorization levels from fiscal year 1988 through fiscal year 1991:

TABLE 1.—OLDER AMERICANS ACT AUTHORIZATION LEVELS, FISCAL YEAR 1988-91

[In thousands of dollars]

Act title	(As contained in P.L. 100-175)			
	1988	1989	1990	1991
TITLE II				
Federal Council on the Aging	$210	$221	$232	$243
TITLE III				
Grants for State and community programs on aging:				
Supportive services and centers	379,575	398,554	418,481	439,406
Nutrition services	645,130	684,837	727,778	773,017
Congregate	(414,750)	(435,488)	(457,262)	(480,125)
Home delivered	(79,380)	(83,349)	(87,516)	(91,892)
USDA commodities	[1] (151,000)	[1] (166,000)	[1] (183,000)	[1] (201,000)
In-home services for frail elderly	25,000	26,250	27,563	28,941
Assistance for special needs	[3] 25,000	[3] 25,000	(3 4)	(3 4)
Health education and promotion	[3] 5,000	[3] [4]	(3 4)	(3 4)
Elder abuse prevention	[3] 5,000	[3] [4]	(3 4)	(3 4)
Long-term care ombudsman	[3] 20,000	(3 4)	(3 4)	(3 4)
Outreach for SSI, Medicaid, and food stamps	(2)	[3] 10,000	[3] 10,000	(4)
TITLE IV				
Training, research, and discretionary projects and programs	32,970	34,619	36,349	38,167
Home care demonstration projects	(2)	[3] 2,000	[3] 2,000	(2)
Ombudsman and advocacy demonstration projects	(2)	[3] 1,000		(2)
TITLE V				
Community service employment for older Americans	386,715	406,051	426,353	447,671
TITLE VI				
Grants for Native Americans	[5] 13,400	[5] 16,265	[5] 19,133	[5] 22,105
Part A—Indian	(12,100)	(14,900)	(17,700)	(20,600)
Part B—Native Hawaiian Program	(1,300)	(1,365)	(1,433)	(1,505)
TITLE VII				
Older Americans personal health education and training program	(6)	(6)	(6)	(6)
Total	[7] 1,538,000	[7] 1,604,797	[7] 1,667,889	[7] 1,749,550

[1] Public Law 100-175 requires the Secretary of Agriculture to maintain a reimbursement level of 56.76 cents per meal for FY 1986-91.

[2] Not authorized.

[3] The law requires that total appropriations for program funded in FY 1987 increase by at least 5 percent over the previous year before appropriations for these new authorizations are made.

[4] Such sums as may be necessary.

[5] The law creates a separate Part B for funds for a Native Hawaiian program. As shown in the table, the law authorizes specific amounts for Part A, the Indian Program, and for Part B. The law further specifies that Part B receive funding only if the total appropriations for title VI exceed the FY 1987 funding level ($7.5 million). Part B will receive the first $250,000 of any appropriations exceeding the FY 1987 level, and half of any increase above the first $250,000 up to the authorized amount.

[6] This title is repealed.

[7] Plus such sums as may be necessary for certain programs.

Source: Congressional Research Service.

2. OLDER AMERICANS ACT APPROPRIATIONS

Although the President's budget request for fiscal year 1990 represented a slight increase over the total fiscal year 1989 appropriations level, it did not fully reflect the impact of the projected rate of inflation on providing services and, for most individual programs, did not reflect any inflation adjustment. For most of the OAA programs the administration requested the same amount in fiscal year 1990 as appropriated in fiscal year 1989. The following table provides a specific breakout by major title areas:

Table 2. Older Americans Act Appropriations, Fiscal Year 1990

[In thousands of dollars]

Title II: Federal Council on Aging	188
Title III:	
Supportive services and senior centers	275,652
Ombudsman activities	[1] 988
Nutrition services:	
Congregate	356,668
Home-delivered	80,046
USDA commodities	141,293
In-home services for frail elderly	5,834
Subtotal, Title III	860,501
Title IV: Training, research, and discretionary projects and programs	25,673
Title V: Community Service Employment	362,000
Title VI: Grants for Native Americans	12,710
Total	1,260,344

[1] Congress appropriated this amount for the ombudsman program despite authorizing legislation requiring an appropriations trigger.

Because sequestration under the Gramm-Rudman budget legislation will reduce Older Americans Act appropriations in fiscal year 1990, the actual appropriation levels will be 5.3 percent below the figures listed above.

In report language, the Senate Appropriations Committee expressed strong support for area agencies on aging providing outreach to assist elderly persons in applying for Federal benefit programs.

3. CONGRESSIONAL HEARINGS AND ACTION

Congress held two hearings on the OAA in 1989. As noted above, the Senate Labor and Human Resources Subcommittee on Aging held a hearing on implementation of the 1987 amendments to the Older Americans Act on May 18, 1989. On June 26, 1989, the Human Resources Subcommittee of the House Education and Labor Committee held a hearing on H.R. 1062, a bill that would require State and local governments to notify area agencies on aging of any attempted evictions or foreclosures of elderly persons.

As 1989 drew to a close, President Bush's delay in announcing plans for the 1991 White House Conference on Aging, authorized under the 1987 amendments to the OAA, became a matter of deep concern to aging advocates in Congress and across America. On June 26, 1989, the House Select Committee on Aging's Human Services Subcommittee held a hearing on the issue. In December, Senator David Pryor, Chairman of the Senate Special Committee on Aging, initiated a letter signed by all members of the committee, urging President Bush to promptly begin preparations for the 1991 conference. In the letter, the members suggested that providing long-term care services to all vulnerable populations, including disabled children and adults, would be an important topic for conference attendees to address.

D. PROGNOSIS

Fiscal year 1990 will mark the 25th anniversary of the Older Americans Act. When first enacted in 1965, the OAA set out a series of objectives aimed at improving the lives of older Americans in such areas as income, health, housing, employment, community services, and gerontological research and education. Since its inception, the gradual evolution of the programs and services authorized by the Act has been remarkable. Although progress has been realized, it has not been without some growing pains.

As originally conceived, the congressional intention underlying the OAA Act was to establish a coordinated and comprehensive system of services at the community level. Such a system, it was asserted, would provide opportunities for and assist vulnerable older persons who, despite advancements in income security and health programs, still needed social services support. Additionally, the structures would provide the supports necessary to promote independent living and reduce the risk of costly institutionalization.

To that end the OAA has been successful. The needs of older persons have been identified and the means for meeting those needs have evolved concurrently. There is now an "aging network" of 57 State units on aging, about 670 area agencies on aging, and more than 25,000 local supportive and nutrition service providers. Additionally, the Act has been the vehicle for the education and training of thousands in the field of aging.

Despite the increase in authorizations for existing programs and adequate authorizations for new programs with the 1987 reauthorization, the programs operated under the Older Americans Act will continue to be overextended and underfunded. Area agencies on aging out of necessity must raise funds from many other sources to support the programs.

Targeting the available resources to specific categories of older persons, those most in need, is a natural consequence of limited funding. It is also inevitable that those who are most pressed for funding resources on the State and local levels will continue to advocate cost-sharing. However, even if cost-sharing was implemented, it is unlikely to generate sufficient funds to finance services necessary to successfully address the many unmet needs of numerous older Americans.

Although the Act prohibits the direct provision of services by an area agency on aging, a waiver may be obtained where the State unit on aging determines either that there is no other agency or organization in the area to provide the services or that the area agency on aging can provide the service more economically. Emphasis on the development of long-term care strategies and the assumption of increasing responsibilities for case management and preadmission assessment have propelled State and area agencies into new functional areas and it is likely that this trend will continue in the future. However, this trend may raise difficult issues, such as potential conflicts of interest, that must be resolved in the years to come.

Without question, future demographic pressures will place increasing burdens on the delivery systems under the Older Americans Act. The challenge for State and area agencies on aging will be not only to maintain necessary services, but also to assure the quality and accessibility of these services. As has been the case in the past, with continued broad support from the Congress, the OAA can be expected to adapt to and be strengthened from these challenges in the years to come.

It is unlikely that Congress will enact any major changes in the Older Americans Act in 1990, as many advocates and Members of Congress will begin to look ahead to the 1991 reauthorization process. Under the direction of Senator David Pryor, the Special Committee on Aging is planning several legislative seminars in 1990 in order to consider pertinent to reauthorization of the OAA.

Chapter 12

SOCIAL, COMMUNITY, AND LEGAL SERVICES

OVERVIEW

Social service programs funded by the Federal Government support a broad range of services to older Americans. These programs provide funds to operate a variety of community and social services including home health programs, legal services, education, transportation, and volunteer opportunities for older Americans.

During the Reagan era, two basic themes emerged with respect to the delivery of social services for the elderly. First, the Administration sought to give States greater discretion in the delivery of social services as part of its "New Federalism" initiatives. Second, the shift toward block grant funding was accompanied by a general trend toward fiscal restraint and retrenchment of the Federal role in human services. As a result, the competition for scarce resources accelerated between the elderly and other needy groups.

In addition to cuts accompanying the block grants, the Reagan Administration proposed to reduce spending for education, transportation, and legal services. These administration efforts affected social service delivery in varying degrees, with the most significant cuts coming in legal services, which it had sought to eliminate entirely. Older American Volunteer Programs, by contrast, enjoyed strong support from the administration.

For the most part, Congress resisted the Reagan Administration's efforts to reduce funding for social, community, and legal services. Following the cuts sustained in the fiscal year 1981 budget, Congress increased spending for the Social Services Block Grant, Community Services Block Grant, and legal services. In fiscal year 1985, Congress significantly increased authorized spending levels for adult education and other education programs benefiting the elderly. However, the focus on Federal spending was clearly framed by the widespread concern over budget deficits.

At the beginning of 1989, advocates of human services programs were hopeful that the combination of a Democratic majority in Congress and President Bush's call for a "kinder, gentler nation" would result in greater Federal resources being devoted to social service programs. Although the political climate with respect to human services was more favorable in 1989, there were few tangible results. Most programs were funded at levels comparable to previous years, and no major new initiatives were enacted.

A. BLOCK GRANTS

1. BACKGROUND

(A) SOCIAL SERVICES BLOCK GRANT

Social services programs are designed to protect individuals from abuse and neglect, help them become self-sufficient, and reduce the need for institutional care. Social services for welfare recipients were not included in the original Social Security Act, although it was later argued that cash benefits alone would not meet all the needs of the poor. Instead, services were provided and funded largely by State and local governments and private charitable agencies. The Federal Government began funding such programs under the Social Security Act in 1956 when Congress authorized a dollar-for-dollar match of State social services funding; however, this matching rate was not sufficient incentive for many States, and few chose to participate. Between 1962 and 1972, the Federal matching amount was increased; and several program changes were made to encourage increased State spending. By 1972, a limit was placed on Federal social services spending because of rapidly rising costs. In 1975, a new Title XX was added to the Social Security Act which consolidated various Federal social services programs and effectively centralized Federal administration.

Title XX provided 75 percent Federal financing for most social services, except family planning which was 90 percent federally funded. The law required that at least half of each State's Federal allotment be used for services to recipients of Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or Medicaid. The remaining funds could be used to provide services to anyone whose income did not exceed 115 percent of the State's median income. Fees were mandatory for individuals with incomes between 80 percent and 115 percent of the State median income. All services provided by a State had to be tied to at least one of five legislative goals that related to self-sufficiency and self-support. At least one service for each of the five goals had to be provided. Further, title XX required States to offer at least three services for aged, blind, or disabled people receiving SSI payments.

In 1981, Congress created the Social Services Block Grant (SSBG) as part of the Omnibus Budget Reconciliation Act. By eliminating most of the restrictions in Title XX, Congress granted the Reagan Administration added flexibility to transfer maximum decision-making authority to the States and reduce domestic Federal spending. Under the block grant program, States no longer are required to provide a minimum level of services to AFDC, SSI, or Medicaid recipients, nor are Federal income eligibility limits imposed. Non-Federal matching requirements were eliminated and Federal standards for services, particularly for child day care, also were dropped. The block grant allows States to design their own mix of services and to establish their own eligibility requirements.

Block grant funds are used for such diverse activities as child day care, home-based services for the elderly, protective and emergency services for children and adults, family planning, transportation, staff training, and program planning.

(B) COMMUNITY SERVICES BLOCK GRANT

The Community Services Block Grant (CSBG) is the current version of the Community Action Program (CAP), which was the centerpiece of the war on poverty of the 1960's. This program originally was administered by the Office of Economic Opportunity within the Executive Office of the President. In 1975, the Office of Economic Opportunity was renamed the Community Services Administration (CSA) and reestablished as an independent agency of the executive branch.

As the cornerstone of the agency's antipoverty activities, the Community Action Program gave seed grants to local, private nonprofit or public organizations designated as the official antipoverty agency for a community. These community action agencies were directed to provide services and activities "having a measurable and potentially major" impact on the causes of poverty. During the agency's 17-year history, numerous antipoverty programs were initiated and spun off to other Federal agencies, including Head Start, legal services, low-income energy assistance and weatherization. Although the agency's budget peaked in fiscal years 1969 and 1970 with an annual funding of $1.9 billion, the funding then steadily declined until fiscal year 1981, when appropriations were $526.4 million.

Under a mandate to assure greater self-sufficiency for the elderly poor, the CSA was instrumental in developing programs that assured access for older persons to existing health, welfare, employment, housing, legal, consumer, education, and other services. Programs designed to meet the needs of the elderly poor in local communities werre carried out through a well-defined advocacy strategy which attempted to better integrate services at both the State level and the point of delivery.

In 1981, the Reagan Administration proposed elimination of the CSA and the consolidation of its activities with 11 other social services programs into a social services block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The administration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs' combined spending levels in fiscal year 1981. Although the General Accounting Office and a Congressional oversight committee had criticized the agency as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) abolished the CSA as a separate agency, but replaced it with the CSBG to be administered by the newly created Office of Community Services under the Department of Health and Human Services.

The CSBG Act requires States to submit an application to the Department of Health and Human Services, promising the State's compliance with certain requirements, and a plan showing how this promise will be carried out. States must guarantee that legislatures will hold hearings each year on the use of funds. States also must agree to use block grants to promote self-sufficiency for low-income persons, to provide emergency food and nutrition services, to coordinate public and private social services programs, and to encourage the use of private-sector entities in antipoverty activities. However, neither the plan nor the State application is subject to the approval of the Secretary of Health and Human Services. States may transfer up to 5 percent of their block grant allotment for use in other programs, such as the Older Americans Act, Headstart, and low-income energy assistance. No more than 5 percent of the funds may be used for administration.

Funding for the new block grant in fiscal year 1982 amounted to a 30 percent reduction from the CSA's fiscal year 1981 appropriation. The CSBG received $348 million in fiscal year 1982, plus an additional $18 million for activities related to the phaseout of the CSA.

Since States had not played a major role in antipoverty activities when the CSA existed, the Reconciliation Act of 1981 offered States the option of not administering the new CSBG during fiscal year 1982. Instead, the Department of Health and Human Services would continue to fund existing grant recipients until the States were ready to take over the program. States which opted not to administer the block grant in 1982 were required to use at least 90 percent of their allotment to fund existing community action agencies and other prior grant recipients. In the act, this 90 percent pass-through requirement applied only during fiscal year 1982. However, in appropriations legislation for fiscal years 1983 and 1984, Congress extended the grandfather provision to ensure program continuity and viability. The extension was viewed widely as an acknowledgement of the political stakes inherent to community action agencies and the programs they administer.

In 1984, Congress made the 90 percent pass-through requirement permanent and applicable to all States, under Public Law 98-558. Currently, over 1,145 eligible service providers receive funds under the 90 percent pass-through. Three-fourths of these entities are community action agencies, the remainder includes limited purpose agencies, migrant or seasonal farmworker organization, local governments or councils of government, and Indian tribes or councils.

In 1989, the National Association for State Community Services Programs released a 50-State survey of programs funded by CSBG. Among the principal finding were: (1) 92 percent of CSBG funds are received by local agencies eligible for the congressionally mandated pass-through; (2) 73 percent of such eligible agencies are community action agencies established under the original Community Action Program. (3) 76 percent of the funds received by CSBG-funded agencies come from Federal programs; (4) 6 percent of funds received by CSBG-funded agencies come from State government sources; and (5) CSBG moneys, constitute only 8 percent of the total funds received by CSBG-funded agencies.

Agencies from 31 States reported detailed information about their uses of CSBG funds. Those agencies used CSBG moneys in the following manner: Emergency services (20 percent), nutrition programs (14 percent), employment programs (13 percent), education initiatives (8 percent), information and referral (8 percent), organizing and advocay (8 percent), neighborhood and economic development (8 percent), income management programs (8 percent), and housing initiatives (6 percent).

2. ISSUES

(A) NEED FOR COMMUNITY SERVICES BLOCK GRANTS

After 2 years of existence, the administration proposed to terminate the CSBG entirely for fiscal year 1984, and to direct States to use other sources of funding for antipoverty programs, particularly SSBG dollars. In justifying this phaseout and suggesting funding through the SSBG, the administration maintained that States would gain greater flexibility because the SSBG included fewer restrictions. According to the administration, States then would be able to develop the mix of services and activities that were most appropriate to the unique social and eonomic needs of their residents.

However, a GAO report refutes this claim.

In May 1986, GAO issued a report on the operation of Community Action Agencies (CAA's) funded by the CSBG. Specifically, the GAO addressed the Reagan Administration's position that:

(1) The type of programs operated under CSBG duplicated social service programs under the SSBG,

(2) CAA's can find other Federal and State funds to cover administrative activities, and

(3) Funding under CSBG is not essential to the continued operation of CAA's.

The report found that, in general, CSBG-funded services often were short-term and did not duplicate those provided under SSBG. Primarily, CSBG funds are used to provide services that fulfill unmet local needs and to complement those services provided by other agencies. Unmet local needs cited by GAO include temporary housing, transportation, and services for the elderly. CSBG-funded agencies provided such complementary programs as the training of day care personnel for SSBG-funded day care programs and temporary shelter for clients awaiting more permanent housing financed by other sources. The most common CSBG-funded services were information, outreach, referral, emergency services, and nutritional services.

GAO also found that CSBG funds often are used for administration of other social service programs which may have limitations on the use of their own funds for administrative expenses. Consequently, CAAs are not in a position to find other Federal and State funds to cover administrative costs. According to GAO, the Federal Government in 1984 provided 89 percent of the total funds received by CAA's in 32 States. The remaining 11 percent of the 1984 budgets of reporting CAA's were provided by CSBG funds. Several other Federal programs, including Head Start, the Community Development Block Grant, and Low Income Home Energy Assistance, provide substantial CAA funding.

The GAO report also did not support the administration's claims that CSBG funding is nonessential to continued program operation. State and local governments are under such fiscal duress that they may not be able to replace lost CSBG funds.

The administration continued to attempt termination of the CSBG in fiscal years 1985–87, requesting funding only to cover administrative expenses of closing down the program. For fiscal years

1988 and 1989, the administration requested $310 million and $282 million respectively for a 4-year phase-out of the CSBG program. Congress, however, has resisted the administration's proposals and has continued to support funding for the operation of the CSBG program.

(B) ELDERLY SHARE OF SERVICES

The role that the SSBG plays in providing services to the elderly had been a major concern to policymakers. Supporters of the SSBG concept have noted that social services can be delivered more efficiently and effectively due to administrative savings and the simplification of Federal requirements. Critics, on the other hand, have opposed the block grant approach because of the broad discretion allowed to States and the loosening of Federal restrictions and targeting provisions that assure a certain level of services for groups such as the elderly. In addition, critics have noted that any future reductions in SSBG funding could trigger uncertainty and increased competition between the elderly and other needy groups for scarce social service resources.

Under Title XX, the extent of program participation on the part of the elderly was difficult to determine because programs were not age specific. States had a great deal of flexibility in reporting under the program, and, as a result, it was hard to identify the number of elderly persons served, as well as the type of services they received. The elimination of many of the reporting requirements under SSBG has made efforts to track services to the elderly even more difficult. States are required to file yearly pre-expenditure reports, but these do not adhere to a standardized format and are of limited value in determining the impact of program and funding changes on specific populations.

The American Association of Retired Persons conducted a telephone survey in 1987 to determine the amount of SSBG funds being used for services to the elderly. The survey showed that 47 States use some portion of their SSBG funds to provide services to older persons. Forty-four of the States submitted estimates on the amount provided, running from less than 1 percent up to 50 percent, with an average of 18 percent. Most States indicated that they have held service levels relatively constant by a variety of devices including appropriating their own funds, cutting staff, transferring programs to other funding sources, requiring local matching funds, or reducing the frequency of services to an individual. The most frequently provided services were home-based, adult protective, adult day care, transportation, and nutrition services. At the same time the areas of unmet need were home-based, adult protective, transportation, and respite services. The majority of States characterized their services as preventive, that is, attempts to maintain the independence of older people in the community. The survey also found that while the level of SSBG funding of services to older persons appears to have held steady or declined only slightly, there nevertheless has been a large decline in the numbers of older persons assisted. This is partially due to focusing on very-low-income persons. This finding is supported by a 1986 Urban Institute report that found that the lowering of income eligibility levels may have reduced the availability of in-home services to older persons.

It seems clear that while funding for the SSBG has remained relatively constant, there is a strong potential for fierce competition among recipient groups. Increasing social service needs along with declining support dollars portends a trend of continuing political struggle between the interests of elderly indigent and those of indigent mothers and children. In the coming years, a fiscal squeeze in social service programs could have massive political reverberations for Congress, the administration, and State governments as policymakers contend with issues of access and equity in the allocation of scarce resources.

The proportion of CSBG funds that support services for the elderly and the extent to which these services have fluctuated as a result of the block grant also remains unclear. When the CSBG was implemented, many of the requirements for data collection previously mandated and maintained under the Community Services Administration were eliminated. States were given broad flexibility in deciding the type of information they would collect under the grant. As a result of the minimal reporting requirements under the CSBG, there is very little information available at the Federal level regarding State use of CSBG funds.

A 1987 study by the Center for Community Futures, in conjunction with the National Association for State Community Services Program (NASCSP), on State use of fiscal year 1986 CSBG funds provides some interesting clues. Although the survey was voluntary, all but six jurisdictions eligible for CSBG allotments answered all or part of the survey. Thus, NASCSP received data on CSBG expenditures broken down by program category and number of persons served which provides an indication of the impact of CSBG services on the elderly. For example, data from 38 States show expenditures for employment services, which includes job training and referral services for the elderly, accounted for 11 percent of total CSSB expenditures in those States and served over one-half million persons. Housing programs, in fiscal year 1986, including home ownership counseling, shelters for the homeless, and construction of low-cost housing, served over 1 million persons, many of whom are elderly. A catchall linkage program category supports a variety of services reaching older persons, including transportation services, medical and dental care, senior center programs, legal services, homemaker and chore services, and information and referrals. Emergency services such as donations of clothing, food and shelter, low-income energy assistance programs and weatherization are provided to the needy elderly through CSBG funds. Unfortunately, data related to the age, sex, race, and income levels of program participants were not reported in the survey, although 18 States reported they collect such statistics. Until such data are available, a definitive picture of the role CSBG programs play in assisting the needy elderly is unclear.

3. FEDERAL RESPONSE

(A) SOCIAL SERVICES BLOCK GRANT APPROPRIATIONS

The 1981 Budget Reconciliation Act fixed authorization levels 20 percent below those in fiscal year 1981, with slight increases for inflation. Authorization levels were set at $2.4 billion in fiscal year 1982, $2.45 billion in fiscal year 1983, $2.5 billion in fiscal year 1984, $2.6 billion in fiscal year 1985, and $2.7 billion in fiscal year 1986 and beyond. The program is permanently authorized. States are entitled to receive a share of the total according to their population size.

For fiscal year 1986, President Reagan requested that the full entitlement level of $2.7 billion be appropriated for the SSBG, and Congress appropriated that amount. However, under the Gramm-Rudman-Hollings deficit-reduction procedures, $116 million was lost through automatic sequestration. Although the Supreme Court invalidated the process, Congress upheld the budget cuts in March 1986 with Public Law 99-366.

The President again requested $2.7 billion for the SSBG for fiscal years 1987-89, the full amount authorized by law. Congress incorporated the $2.7 billion into a governmentwide continuing appropriations resolution for fiscal year 1987 (P.L. 99-591) and authorized a one-time $50 million increase for fiscal year 1988 for a total of $2.75 billion (P.L. 100-202). Congress appropriated the full authorized amount of $2.7 billion again for fiscal years 1989 (P.L. 100-436) and 1990 (P.L. 101-96).

(B) COMMUNITY SERVICES BLOCK GRANT REAUTHORIZATION AND APPROPRIATIONS

As established in the 1981 Omnibus Budget Reconciliation Act, the CSBG was scheduled to expire at the end of fiscal year 1986. The Human Service Reauthorization Act of 1986 (P.L. 99-425) has since extended the CSBG Act through fiscal year 1990 at the following levels: $390 million for fiscal year 1987, $409.5 million for fiscal year 1988, $430 million for fiscal year 1989, and $451.5 million for 1990. Of the total appropriated each year, the Secretary of the Department of Health and Human Services is authorized to reserve up to 9 percent for discretionary use. The remaining funds are allotted to States in the same proportion as the amounts that the States received in fiscal 1981 from CSA. Ninety percent of the State allotments must be used to fund eligible service providers.

The act also authorizes $4 million annually through fiscal year 1990 for the Community Food and Nutrition Program, and authorizes an additional $5 million annually, through fiscal year 1989, for a demonstration program of innovative antipoverty approaches. The Stewart McKinney Homeless Assistance Act authorized appropriations for grants to States for services to the homeless.

The Reagan Administration submitted similar budget requests for the CSBG for several years. It hoped to close down the CSBG during each of the fiscal years 1984 through 1987. For example, only $3.6 million was requested for fiscal year 1987 to cover Federal administrative expenses related to the phasing out of the program. However, Congress continually rejected these proposals and appropriated funds for CSBG throughout the Reagan years.

Congress appropriated $396 million for CSBG in fiscal year 1990, including $3.5 million for community partnerships and $2.4 million for homeless services.

CSBG authorization expires at the end of fiscal year 1990. The anticipated reauthorization of CSBG may raise many critical issues in 1990. At this point, the likely agenda for CSBG remains unclear.

B. EDUCATION

1. Background

State and local governments have long had primary responsibility for the development, implementation, and administration of primary, secondary, and higher education, as well as continuing education programs that benefit students of all ages. The role of the Federal Government in education has been to ensure equal opportunity, to enhance the quality, and to address national priorities in training.

Federal and State interest in developing educational opportunities for older persons grew out of a paper prepared for the 1971 White House Conference on Aging which cited a list of educational needs for older persons. These range from the need to acquire the basic skills necessary to function in society to the need to engage in activities throughout one's life which are enjoyable and meaningful and which benefit other people. The 1981 White House Conference on Aging report, entitled "Implications for Educational Systems," noted that as our society ages at an accelerated rate, it must assess and redefine the teaching and learning roles of older persons and assure a match between the needs of older adults and the training of those who serve them.

While many strong arguments exist for the importance of formal and informal educational opportunities for older persons, it has traditionally been a low priority in education policymaking. Public and private resources for the support of education have been directed primarily at the establishment and maintenance of programs for children and youth, including those of the traditional college ages. This is due largely to the perception of education as a foundation constructed in the early stages of human development.

While formal education is viewed as a finite activity extending only through early adulthood, learning continues throughout one's life in experiences with work, family, and friends. Thus, it is a relatively new notion that a need exists for learning beyond the informal environment for the elderly. This need for structured learning may appeal to "returning students" who have not completed their formal education, older workers who require retraining in skills adaptable to rapid technological change, or retirees who desire to expand their knowledge and personal development. A growing awareness of the importance of education to the elderly has resulted in some reordering of priorities and resource allocation away from the basic education/literacy and training programs established for older adults in the early 1960's. While Federal programs generally have lagged, private and public-based education programs have emerged that are designed to better meet the growing educational needs of older persons.

2. Issues

(A) ADULT LITERACY

Conventional literacy means the ability to read and write. The Census Bureau estimated that the Nation's conventional illiteracy rate was 0.5 percent in 1980, which would place the estimated number at over 1 million. However, literacy means more than just the ability to read and write. The term "functional illiteracy" began to be used during the 1940's and 1950's to describe persons who were incapable of understanding written instructions necessary to accomplish specific tasks or functions.

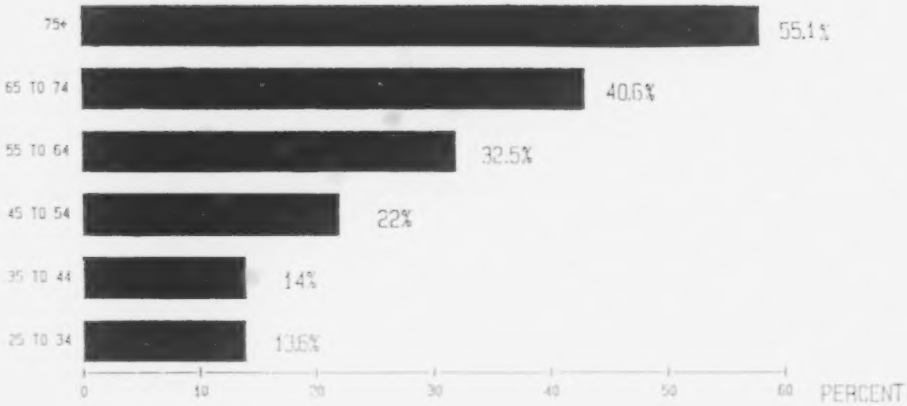
Definitions of functional literacy depend on the specific tasks, skills, or objectives thought necessary for the comprehension of a literate person. As various experts defined clusters of needed skills, definitions proliferated. These definitions became more complex as the technological and informational needs of the society increased. Thus, despite apparent consensus that some measure of functional illiteracy must replace the conventional definition, no agreement has been reached. Without a standard definition and widely accepted measure of illiteracy, it is difficult to determine the extent of illiteracy in the country and whether it is increasing or decreasing.

The results of some studies, however, have revealed cause for concern. In a 1986 study of illiteracy by the National Advisory Council on Adult Education, an estimated 40 percent of armed services enlistees were found to read below the 9th grade level. An estimated two-thirds of the Nation's colleges find it necessary to provide remedial reading and writing courses. When the inherent problems associated with illiteracy are considered—unemployment, crime, homelessness, alcohol and drug abuse—the social consequences of widespread illiteracy in this country are disturbing.

Of all adults, the group 60 years of age and older has the highest percentage of people who are functionally illiterate. Results of one study showed that 35 percent of adults 60 to 65 years of age lack the skills and knowledge necessary to cope successfully in today's society. According to 1982 census data, nearly one-third of all illiterate adults are age 60 and over. These figures reflect the direct correlation between educational attainment and literacy. As would be expected, there is a heavy concentration of older persons among the groups of adults of 16 years and over with than a high school education.

CHART 1

PERCENT OF AGE GROUPS WITH LESS THAN 12 YEARS OF EDUCATION: 1987



Source: U.S. Bureau of Census, Current Population Survey, March, 1988

Data from the Office of Vocational and Adult Education within the Department of Education, shows that of the total eligible adult population receiving Adult Basic Education services (ABE)—basic literacy and English as a second language instruction—in 1986, 7.4 percent or 217,488 were in the 60-plus age group as compared to 185,000 the previous year—an 11.8-percent increase. On the State levels, the percentages of older adult participation in literacy instruction varied from less than 1 percent to 20 percent. The reasons for participation in literacy programs most often cited by this group were: (1) To read to their grandchildren, (2) to read the Bible, (3) to read medicine labels, (4) to accomplish a life time goal of earning a General Education Development (GED) certificate, (5) to learn more about money and banking, and (6) to learn more about available community resources.

(B) PARTICIPATION IN ADULT EDUCATION

The Department of Education is authorized under the Adult Education Act (AEA) to provide funds for educational programs and support services benefiting all segments of the eligible adult population. The purpose of the act is to: (a) Establish adult education programs to help persons 16 years and older to acquire basic literacy skills necessary to function in society, (b) enable adults to complete a secondary school education, and (c) make available to adults the means to secure training and education that will enable them to become more employable, productive, and responsible citizens. Funds provided for adult education are distributed by a formula to States based on the number of adults in a State without high school diplomas who currently are not enrolled in school. The AEA serves almost 3.5 million participants annually.

In 1977, a major change began in adult education. Enrollment of persons aged 16 to 44 decreased while the numbers of persons 45 to 65 increased. A 1984 survey conducted by the National Center for Education Statistics revealed that 866,000 persons age 65 and older, or 3.3 percent of all older Americans, participated in educational activities. Although the majority of adult education participants are under 35, this marked the highest number and percentage of older people involved in adult education ever recorded by the National Center for Education Statistics. However, this represents an increase of only 0.2 percent from a similar 1981 study.

With less than 4 percent of the elderly population enrolled in an educational institution or program today, older Americans continue to be underrepresented in education programs in relation to the percentage of the total U.S. adult population they comprise. This is due partly to the fact that while the elderly certainly have the ability to learn, the desire to learn is a function of educational experience. A 1984 Department of Education report supports the correlation between years of schooling completed and participation in adult education.

The existence of special classes and programs geared to older adults within structured adult education programs is still relatively rare except in community senior centers. Most the classes focus on self-enrichment and life-coping skills and gradually are shifting to educational programs on self-sufficiency. Few programs currently exist to meet the growing demand for the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, and older persons look to continued employment as a source of economic security, adult education programs may need to shift emphasis from personal interest courses to include courses on job-training skills.

Although States use various methods for reaching the eligible aging population, reports indicate that there are problems in carrying out this effort. The major problems most often mentioned by States are transportation and recruitment. Reaching older persons, especially in rural areas, is complicated because of distance and low population density. Lack of transportation in rural areas hinders program participation by the elderly, and programs may be offered at locations that are hard to reach.

3. Federal and Private Response

(A) PROGRAMS

(1) Literacy

(a) Public Efforts

The first significant Federal adult literacy programs began in the military services. Programs for civilians started with the Manpower Development and Training Act of 1964, providing job training for the unemployed. Many participants were found to be functionally illiterate and the program was amended to provide basic educational skills. The Economic Opportunity Act of 1964 provided the first State grants for persons needing basic literacy skills. The Adult Education Act was enacted as part of the Elementary and Secondary Education Amendments of 1966 (P.L. 89-750). The act has been amended several times since 1966, but the basic purpose and structure have remained similar since then.

During its first term, the Reagan Administration requested a one-third reduction of Federal funds for the Adult Education Act, with the ultimate intent of turning over such programs to the States under the "Federalism Initiative." In response to the President's Commission on Excellence in Education report, the Reagan Administration made the elimination of illiteracy a major focus. The Adult Literacy Initiative was launched in the Department of Education on September 7, 1983. It is not, a legislatively mandated program, but is based on various discretionary authorities available to the Secretary of Education. The thrust of the initiative is to increase public awareness of the problem, recruit volunteer tutors, and encourage private sector involvement.

The program's current accomplishments include:

(1) Cooperating with the Coalition for Literacy and the Advertising Council in sponsoring a National Awareness Campaign on adult literacy, including a toll-free "Literacy Hotline",

(2) Redirecting part of the College Work-Study Program to employ students in literacy programs,

(3) Encouraging student and adult volunteers as literacy tutors,

(4) Working with the Federal Employee Literacy Training program, whereby all Federal agencies are encouraging employees to volunteer as literacy tutors,

(5) Sponsoring national meetings and conferences, and

(6) Developing private/public sector partnerships, including support for the Business Council for Effective Literacy.

The Department of Education's Office of Educational Research and Improvement sponsored the National Adult Literacy Project, which issued research reports in 1985 on a number of topics, including history and description of adult basic education programs, literacy and employment, an agenda for literacy research and development, support systems for adult education, literacy, and television, alternative strategies for adult education participation, and a guidebook on effective literacy projects.

Much of the public effort by States and localities to address literacy problems is organized under the AEA program, which is federally funded and State administered. Section 353 of the AEA requires States to set aside 10 percent of their Federal funds for Special Experimental Demonstration and Teacher Training projects. The section calls for coordinated approaches to the delivery of Adult Basic Education services to promote effective programs and to develop innovative methods. Some of the States developed projects targeted to improve literacy services to the older population. For example, Louisiana developed a set of basic skills curricula for adults reading at the 0–4 grade levels, and West Virginia used cable television to reach the disadvantaged who live in rural areas, are institutionalized, homebound, or isolated.

(b) Private Efforts

Literacy programs are operated by a multitude of private groups including churches, businesses, labor unions, civic and ethnic groups, community and neighborhood associations, museums and galleries, and PTA groups. Two national groups provide voluntary tutors and instructional materials for private literacy programs, the Laubach Literacy Action (30,000 tutors) and Literacy Volunteers of America (15,000 tutors). At the instigation of the American Library Association, a group of 11 national organizations, including Laubach and Literacy Volunteers, created the Coalition for Literacy to deliver information and services at the national and local levels. The Coalition and the Advertising Council began a 3-year advertising project in December 1984, the National Literacy Awareness Campaign, to increase public awareness and recruit literacy volunteers.

The Business Council for Effective Literacy is a foundation established in 1984 to foster "corporate awareness of adult functional illiteracy and to increase business involvement in the literacy field." The Council's quarterly newsletters contain descriptions of many current public and private literacy efforts.

(2) Higher Education

Older persons bring insight, interest, and commitment to learning that can generate similar enthusiasm from younger classmates, and can add to the personal satisfication of learning. A logical extension of the success of intergenerational school programs is the intergenerational classroom at the college level. A recent study found that younger students studying together with persons their parents' and grandparents' age broadened their attitude toward older persons beyond rigid stereotypes and were able to identify them as peers. This finding rebukes the myth that older students somehow take away learning opportunities from younger students, and indicates a growing need to think of older adults as a vital part of the college classroom.

Some colleges have designed continuing education programs to provide the flexibility and support older students often need when reentering college after several years. Approximately 93 colleges and universities participate in the College Centers for Older Learners (CCOL) program. The two most common variations of this program are either those curricula that are planned and implemented exclusively by older persons, or those that are designed and managed by the institution with involvement of older students in the program planning.

Other colleges recognize experience as credit hours. At American University in Washington, DC, for example, the Assessment of Prior Experimental Learning (APEL) program allows older students to translate their years of work or life experience into as many as 30 credits toward a bachelor's degree.

For those older students who cannot afford the cost of a private college, some States are moving to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer full tuition waiver and allow participants to take regular courses for credit in State-supported institutions. The Older Americans Act (OAA) Amendments of 1987 (P.L. 100-175), include a new provision which requires area agencies on aging to conduct a survey on the availability of tuition-free post-secondary education in their area, supplement the data where necessary, and disseminate this information through senior centers, congregate nutrition sites, and other appropriate locations. It is anticipated that access to such information will increase the enrollment of older persons in higher education programs.

(3) Elderhostel

Elderhostel was inspired by the youth hostels and folk schools of Europe, and is based on the belief that retirement and later life represents an opportunity to enjoy new experiences. Elderhostels are short-term residential, campus-based educational programs provided to older persons at modest cost. Courses offered are in the liberal arts and sciences and presuppose no particular level of formal education on the part of the student. Most Elderhostel programs deliberately avoid age-specific focus on the problems of aging.

Since the inception of Elderhostel in New Hampshire in 1975, older adults in dramatically increasing numbers have enrolled in the programs. In 1988, more than 900 private and public colleges and educational institutions in 50 States and Canada served 163,000 summer and academic year hostelers. In addition, hostelers participated in programs in 40 other countries including Scandinavia, France, Germany, the Netherlands, Italy, Great Britain, Israel, and Australia. Even with the burgeoning numbers of participants, however, Elderhostel remains essentially an educational opportunity reserved for mobile older adults with a relatively high education attainment level.

(4) Intergenerational Programs

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasingly age-segregated society in which few opportunities exist for meaningful contact between older adults and youth. Initially, programs were designed and implemented with an emphasis toward providing the support, teaching, and caring that would enhance the learning and development of schoolchildren. Eventually, intergenerational school programs emerged as a viable means of enriching the lives of older persons as well. There are now more than 100 intergenerational school programs nationwide. More than 250,000 volunteers participate in grades kindergarten through 12.

Intergenerational school programs range from informal and haphazard to large, centrally organized projects spanning several school districts. One example of a successful intergenerational program is the Teaching Learning Community, begun by an elementary art teacher in 1971 in Ann Arbor, MI. Teaching Learning Community links older persons with a small group of student-apprentices. They work together on a joint activity on a regular, weekly basis with the focus on teaching the student a new skill and creating a product while communicating with and developing respect and regard for others. The program has spread to many States, including Florida, Pennsylvania, Idaho, Texas, and New York.

Whatever the size or scope, intergenerational school programs contribute immeasurably toward improving older persons' self-esteem and life satisfaction. School volunteering provides an opportunity for older persons to develop meaningful relationships with children and to better cope with their own personal traumas, such as the death of a spouse or friend. These programs also allow schoolchildren to develop a more positive view of the elderly while benefiting from the social and academic experience of their older tutors.

The Federal role in promoting intergenerational school programs has expanded recently through a joint initiative sponsored by the Administration on Aging and the Administration for Children, Youth, and Families in the Department of Health and Human Services. This Federal effort consists of four major components:

(1) Establishing an information bank of intergenerational programs across the country,

(2) Disseminating this information to organizations interested in establishing such programs,

(3) Working with professional organizations to stimulate interest, and,

(4) Funding intergenerational demonstration projects. For example, the Administration on Aging, working cooperatively with 12 foundations, has funded 9 intergenerational projects throughout the country. These projects include intergenerational child care programs; a telephone help line operated by

frail elderly for latch key children; senior homesharing; and a senior mentor program.

The Older Americans Act Amendments of 1987 include a provision that allows the Commissioner on Aging to award demonstration grants, providing expanded, innovative volunteer opportunities to older persons which are designed to fulfill unmet community needs. These projects may include intergenerational services by older persons to meet the needs of children in day care and school settings.

(B) LEGISLATION

In 1989, Congress enacted no major measures related to the Adult Education Act and other literacy/education programs. However, several pieces of legislation passed in 1988 remain of interest to those following adult literacy and education issues:

(1) The Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 became Public Law 100-297 on April 28, 1988. This legislation amends and extends the AEA through fiscal year 1993 and strengthens AEA provisions for programs serving educationally disadvantaged adults. Two new AEA programs are authorized: workplace literacy partnership grants and English literacy grants. Demonstration grants for literacy partnerships provide adult literacy and training skills to improve the productivity of the workforce. Partnerships consist of (a) business, industry, labor organizations, or private industry councils, and (b) State or local educational agencies, institutions of higher education, or schools. Demonstration grants for English literacy assist programs for adults with limited-English proficiency. The amendments also authorize an "even start" program for adult literacy for parents and their children.

Further, the amendments require the Secretary of Education to establish an information clearinghouse on literacy curricula, define the basic skills needed for literacy and estimate the number of illiterate adults in the country. In addition, the Secretaries of the Departments of Education, Labor, and Health and Human Services are required to conduct a joint study of Federal funding sources and services currently available for adult education programs and are to jointly facilitate interagency coordination. The findings of the study are to be submitted to Congress within 2 years.

The Hawkins-Stafford Amendments also extend the Ellender Fellowship program. Ellender grants are made to the Close-Up Foundation which provides educational programs on Federal Government activities and public affairs, usually bringing participants to Washington, DC, for this purpose. A new provision authorizes fellowships for older Americans and recent immigrants.

(2) The Stewart B. McKinney Homeless Assistance Act of 1987 (P.L. 100-77) authorized an Adult Education for the Homeless program of statewide literacy initiatives for grants to States to develop and implement a program of literacy training and basic skills remediation. The States, in turn, coordinate these programs with community-based organizations, VISTA recipients, adult basic education program recipients, and nonprofit literacy-action groups.

Funds are allocated according to each State's homeless population, with each State receiving at least $75,000.

Section 701 of the McKinney Act also amends the Adult Education Act to include homeless individuals as a category in the Research and Demonstration program. The Stewart B. McKinney Homeless Assistance Amendments Act of 1988 (P.L. 100-628) reauthorized the two programs for 2 years, through fiscal year 1990.

(3) The Omnibus Trade and Competitiveness Act of 1988 was signed into law on August 23, as Public Law 100-418. The Trade Act contains several identical or similar provisions, such as the partnership and English literacy grants, as are within the Hawkins-Stafford Amendments. Among the vocational, postsecondary, and adult education provisions, the Act creates a Federal Literacy Coordination Office, directs and National Diffusion Network to disseminate literacy skills information, establishes a technological literacy demonstration program, and amends the Job Training Partnership Act (JPTA) to provide employment and training assistance for dislocated workers, including basic and remedial education and literacy and English training for non-English speaking persons.

Although Congress did not authorize new adult education and literacy initiatives in 1989, it did increase fiscal year 1990 appropriations for existing programs. The Adult Education programs received a combined appropriation of $197.9 million for fiscal year 1990, including $10 million for homeless literacy, $20 million for literacy partnerships, and $5.9 million for English literacy. The AEA grants to States total $160 million for fiscal year 1990, a substantial increase over the fiscal year 1989 level.

The principal legislative development in this adult education in 1989 was the reporting of the National Literacy Act of 1989 by the Senator Labor and Human Resources Committee. This legislation, originally sponsored by Senator Paul Simon (D-IL), would require the Secretary of Education to coordinate Federal literacy activities, increase authorization levels for the Basic State Grants under the AEA, establish the Families for Literacy program (emphasizing intergenerational literacy efforts), encourage distribution of inexpensive books to children with special needs, reauthorize the Student Literacy Corps, and create new volunteer literacy initiatives. It is expected that the Senate will consider this proposal in 1990.

C. ACTION PROGRAMS

1. Background

ACTION was established in 1971 through a Presidential reorganization plan that brought together under one independent agency several existing volunteer programs. The programs transferred to ACTION in 1971 include Volunteers in Service to America (VISTA) and the National Student Volunteer Program, both previously administered by the Office of Economic Opportunity, and the Foster Grandparent Program (FGP) and Retired Senior Volunteer Program (RSVP), which had been part of the Administration on Aging.

ACTION was given statutory authority under the Domestic Volunteer Service Act of 1973, which placed all domestic volunteer programs under a single authorizing statute. The act was reauthorized in 1989 through fiscal year 1993.

Today, programs administered by ACTION include the Title I-A VISTA program, the Title I-B student community service programs, the Title I-C special volunteer programs, and the Title II Older American Volunteer Programs (FGP, RSVP, and the Senior Companion Program (SCP)). ACTION programs are directed toward reducing poverty and poverty related problems, helping the physically and mentally disabled, and assisting in a variety of other community service activities. ACTION also supports demonstration projects for testing new initiatives in voluntarism, and advocates and promotes voluntarism in the public and private sectors.

(A) OLDER AMERICAN VOLUNTEER PROGRAMS

The Older American Volunteer Program (OAVP), which includes the RSVP, the FGP, and the SCP, is the largest of the ACTION program components. For fiscal year 1989, OAVP funding constituted 67 percent of total ACTION funding, and continues to support the majority of ACTION's volunteer strength. The various programs provide opportunities for persons 60 and older to work part time in a variety of community service activities. Grants are awarded to local private nonprofit or public sponsoring agencies that recruit, place, supervise, and support older volunteers.

A significant facet of the OAVP is the extent to which Federal funding is supplemented by State and local governments, as well as private sector resources. According to ACTION estimates, non-Federal funding to support ACTION-sponsored volunteer projects is estimated at more than $60 million annually. In the past few years, State funds to support each of the programs have exceeded the Federal requirements for matching funds. Because these projects continue to generate additional funding at the State and local level and are a cost-effective means of providing community services they are enormously popular with both Congress and the administration.

(1) Retired Senior Volunteer Program

Retired Senior Volunteer Program (RSVP) was authorized in 1969 under the Older Americans Act. In 1971, the program was transferred from the Administration on Aging to ACTION and in 1973 the program was incorporated under Title II of the Domestic Volunteer Service Act. RSVP is designed to provide a variety of volunteer opportunities for persons 60 and older. In fiscal year 1989 there were 750 projects and 400,000 RSVP volunteers who are estimated to have generated approximately 73 million volunteer hours. This includes volunteers supported by non-Federal funds as well as federally funded volunteers.

Volunteers serve in such areas as youth counseling, literacy enhancement, in-home care, consumer education, crime prevention, and housing rehabilitation. Program sponsors include State and local governments, universities and colleges, community organizations, and senior service groups.

Each project is locally planned, operated, and controlled. Although volunteers do not receive hourly stipends as under the

Foster Grandparent and Senior Companion Programs, they receive reimbursement for out-of-pocket expenses incurred as a result of the volunteer activities.

(2) Foster Grandparent Program

The Foster Grandparent Program (FGP) originated in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. It was authorized under the Older Americans Act in 1969 and 2 years later transferred from the Administration on Aging to ACTION. In 1973, the FGP was incorporated under Title II of the Domestic Volunteer Service Act.

The FGP provides part-time volunteer opportunities for low-income persons 60 and older to assist them in providing supportive services to children with physical, mental, emotional, or social disabilities. Foster grandparents are placed with nonprofit sponsoring agencies such as schools, hospitals, day-care centers, and institutions for the mentally or physically handicapped. Volunteers serve 20 hours a week and provide care on a one-to-one basis to three or four children. A foster grandparent may continue to provide services to a mentally retarded person over 21 years of age as long as that person was receiving services under the program prior to becoming 21.

Volunteers receive an hourly stipend, transportation assistance, an annual physical examination, insurance benefits, and meals when serving as volunteers. The Domestic Volunteer Service Act exempts stipends from taxation and from being treated as wages or compensation. Foster grandparent volunteers must have an income below the higher of 125 percent of the Department of Health and Human Services poverty guidelines or 100 percent of those guidelines plus the amount each State supplements the Federal Supplemental Security Income payment. In 1989, this annual income level was $7,475 for an individual in most States and $10,025 for a two-person family. For fiscal year 1989, ACTION estimated that about 27,600 federally and nonfederally funded foster grandparents assisted approximately 70,000 children in 262 projects.

(3) Senior Companion Program

The Senior Companion Program (SCP) was authorized in 1973 by Public Law 93-113 and incorporated under Title II, section 211(b) of the Domestic Volunteer Service Act of 1973. The Omnibus Budget Reconciliation Act of 1981 amended section 211 of the act to create a separate Part C containing the authorization for the Senior Companion Program. This program is designed to provide part-time volunteer opportunities for low-income persons 60 and older to assist them in providing supportive services to vulnerable, frail older persons. The volunteers assist homebound, chronically disabled older persons to maintain independent living arrangements in their own residences. Volunteers also provide services to institutionalized older persons and seniors enrolled in community health care programs. Senior companions serve 20 hours a week and receive the same stipend and benefits as foster grandparents. To participate in the program, volunteers must meet the same income test as for the Foster Grandparent Program.

In fiscal year 1989, about 12,500 SCP volunteers served in 142 projects, including volunteers in nonfederally funded projects. ACTION estimates that these volunteers served over 30,000 persons.

(B) VOLUNTEERS IN SERVICE TO AMERICA

Volunteers in Service to America (VISTA) was originally authorized in 1964, conceived as a domestic peace corps for volunteers to serve full-time in projects designed to reduce poverty. Today, VISTA still holds this mandate. Volunteers 18 and older serve in community activities to reduce or eliminate poverty and poverty-related problems. Activities include assisting the handicapped, the homeless, the jobless, the hungry, and the illiterate or functionally illiterate. Other activities include addressing problems related to alcohol abuse and drug abuse, and assisting in economic development, remedial education, legal and employment counseling, and other activities that help communities and individuals become self-sufficient. Volunteers also serve on Indian reservations, in federally assisted migrant worker programs and in federally assisted institutions for the mentally ill and mentally retarded.

Volunteers are expected to work full-time for a minimum of 1 year, but they may serve for up to 5 years. To the maximum extent possible, they live among and at the economic level of the people they serve. Volunteers are reimbursed for certain travel expenses and receive a subsistence allowance for food, lodging, and incidental expenses. The subsistence allowance may not be less than 95 percent of the poverty line for the area in which the volunteer is serving. They also are provided health insurance and receive a monthly stipend not to exceed $75 ($90 in fiscal year 1991; $95 in subsequent years) that is paid in a lump sum at the end of their service. The 1989 reauthorization legislation requires that at least 20 percent of the volunteers fall into each of two age categories: (a) persons 55 years and older, and (b) persons 18–27 years old.

2. ISSUES

In recent years, there has been a strong resurgence of interest in the role that volunteers can play in both the public and the private nonprofit community service delivery system. Volunteer service has been a traditional means by which individuals and organizations have helped to meet social and cultural needs in society. Historically, voluntarism has been thought of as a commitment of time and resources to institutions and organizations such as hospitals, nursing homes, shelters for the homeless and abused, schools, churches, and other social service agencies. More recently, volunteer service has included activities for grassroots political advocacy and community improvement programs. In many communities, the need continues for volunteer efforts to address the problems of poverty and to utilize the skills and experiences of volunteers, notably the elderly. Despite the interest among volunteer programs to utilize elderly volunteers, there has been relatively little structured evaluation of this mechanism for providing care and services.

In the Domestic Volunteer Service Act Amendments of 1984 (P.L. 98-288), Congress authorized senior companion demonstration projects to explore ways that the Senior Companion Program could serve the growing population of frail homebound older persons at high risk of institutionalization. To accomplish this, SCP was authorized to recruit unpaid community volunteers to train senior companions and to use senior companion volunteer leaders (SCVLs) to assist other senior companions. Grants were awarded to 19 new SCP projects and 17 new components of existing SCP projects at the beginning of fiscal year 1986.

In a search for relevant public policy to meet the long-term care needs of the rapidly increasing older population, Congress mandated an evaluation of the demonstration projects specifying five issues:

(1) The extent to which the costs of providing long-term care are reduced by using SCP volunteer companions, who receive modest stipends, to assist the frail elderly living at home;

(2) The effectiveness of long-term care services provided by volunteers;

(3) The extent to which the health care needs and health-related costs of the volunteer companions are affected by their participation in SCP;

(4) The extent of SCP project coordination with other Federal and State efforts aimed at enabling older individuals to receive care in their own homes; and

(5) The effectiveness of using Senior Companion Volunteer Leaders and Volunteer Trainers.

The evaluation of the new projects, completed in 1988, points out that SCP services supplement and augment long-term care services from other sources, rather than displacing them. Nevertheless, the projects proved to be a relatively low-cost means of providing needed services to frail older persons who could generally not afford to purchase them. However, cost containment is not the only rationale for developing long-term care policy. Improving the quality of life and well-being of the elderly are also major long-term care goals.

The value of the program to the senior companions is demonstrated by the economic benefit of the stipend and the stability of the senior companions' high degree of social integration and wellbeing. Senior companions generally benefited from training by volunteers; however, pre-service as well as in-service training is already a requirement of the Senior Companion Program. It is unclear whether the benefits of utilizing volunteer trainers differ significantly from paid staff trainers.

The position of Senior Companion Volunteer Leaders (SCVL) was not successfully implemented in many of the projects. This reflects the concern expressed by project staffs that the role of SCVLs established a hierarchy among the volunteers, thereby jeopardizing senior companion relationships. Senior companions were found generally to provide informal support services for each other regardless of the presence of SCVLs. Finally, the evaluation found that the most significant impediment to matching companions and clients in the projects, urban or rural, was the lack of access to transportation, another issue to be addressed in implementing long-term care policy.

Associations representing local project directors experienced with administering the Older Americans Volunteers Programs have identified for Congress a major concern for successful continuation of the programs: the need for increased funding support for administration of the projects. Due to administrative restrictions, cost-of-living increases for the Older Americans Volunteer Programs approved by Congress in the past have resulted in an expansion of volunteer services without a corresponding increase for administrative costs. Consequently, for over 10 years project directors have been faced with the increasingly difficult task of supervising a greater number of volunteers without additional support.

3. Federal Response

Congress enacted the Domestic Volunteer Service Act Amendments of 1989 (P.L. 101-204). These amendments reauthorized all ACTION agency programs through 1993 and made several minor changes in existing law. The major modifications contained in the 1989 amendments were two provisions designed to increase volunteer recruitment. The 1989 amendments specifically require ACTION to establish a VISTA recruitment program and to reserve a portion of its annual budget for recruitment activities.

The 1989 amendments established the following authorization levels for older American volunteer programs through 1993: VISTA ($30.6 million, FY 1990; $39.9 million, FY 1991; $47.8 million, FY 1992; $56 million, FY 1993), RSVP ($39.9 million, FY 1990; $43.9 million, FY 1991; $48.3 million, FY 1992; $53.1 million, FY 1993), Foster Grandparents Program ($70.8 million, FY 1990; $80.9 million, FY 1991; $91.7 million, FY 1992; $98.2 million, FY 1993), and the Senior Companion Program ($36.6 million, FY 1990; $39 million, FY 1991; $44.7 million, FY 1992; $48.7 million, FY 1993).

Congress increased appropriations for ACTION programs in fiscal year 1990. Appropriations for older American volunteer programs were as follows: VISTA ($29.4 million), RSVP ($31.9 million), Foster Grandparents Program ($60.4 million), and Senior Companion Program ($27 million)

It is expected that Congress will not make any changes in the ACTION programs in 1990. Advocates and policymaker will be monitoring how well ACTION implements the 1989 amendments, particularly the VISTA recruitment provisions.

D. TRANSPORTATION

1. Background

Transportation is the vital connecting link between home and community. For the elderly and nonelderly alike, adequate transportation is necessary for the fulfillment of most basic needs—maintaining relations with friends and family, commuting to work, grocery shopping, and engaging in social and recreational activities. Housing, medical, financial, and social services are useful only to the extent that transporation can make them accessible to those in need. Transportation serves both human and economic needs. It can enrich an older person's life by expanding opportunities for social interaction and community involvement, and it can support an individual's capacity for independent living, thus reducing or eliminating the need for institutional care.

Three strategies have marked the Federal Government's role in providing transportation services to the elderly:

(1) Direct provision (funding capital and operating costs for transit systems),

(2) Reimbursement for transportation costs, and

(3) Fare reduction.

In fiscal years 1981-89, the Reagan Administration proposed to eliminate or substantially reduce Federal operating subsidies to States for transportation programs. This proposal was indicative of the trend to shift fiscal responsibility for transportation programs to the States and of a general retrenchment on the part of the Federal Government to support further transportation systems.

The major federally sponsored transportation programs that provide assistance to the elderly and handicapped are administered by the Department of Health and Human Services (DHHS) and the Department of Transportation (DOT). Under DHHS, a number of programs provide specialized transportation services for the elderly, including Title III of the Older Americans Act (OAA), the Social Services Block Grant Program (SSBG), the Community Services Block Grant Program (CSBG) and, to a limited extent Medicaid, which will reimburse elderly poor for transportation costs to medical facilities. Under CSBG, more dollars (approximately 32 percent) are spent on so-called linkages with other programs—including transportation for the elderly and handicapped which links clients to senior centers, community and medical services—than on any other program category.

The passage of the OAA of 1965 has had a major impact on the development of transportation for older persons. Under Title III of the act, States are required to spend an adequate proportion of their Title III-B funds on three categories: Access services (transportation and other supportive services); in-home, and legal services. In fiscal year 1989, nearly 7 million persons were recipients of transportation services under the OAA. Approximately 10 percent of OAA funds are used for transportation services. This level of participation and funding indicates the demand for transportation services by the elderly at the local level and the extent to which this network of supportive services provides assistance and relief to needy elderly nationwide.

The passage of the 1970 amendments to the Urban Mass Transit Act (UMTA) of 1964 (P.L. 98-453), which added section 16, marked the beginning of special efforts to plan, design, and set aside funds for the purpose of modifying transportation facilities for improved access by the elderly and handicapped. Section 16 of UMTA declares it to be national policy that elderly and handicapped persons have the same rights as other persons to utilize mass transportation facilities and services. Section 16 also states that special efforts shall be made in the planning and design of mass transportation facilities and services so that the availability to the elderly and handicapped persons of mass transportation is assured, and that all Federal programs offering assistance in the field of mass transportation should contain provisions implementing this policy. Essentially, the goal of section 16 programs is to provide assistance in meeting the transportation needs of elderly and handicapped persons where public transportation services are unavailable, insufficient, or inappropriate. A total of $300 million has been obligated between fiscal years 1975 and 1987 for the purchase of specialized vehicles and equipment.

Another significant initiative was the enactment of the National Mass Transportation Assistance Act of 1974 (P.L. 93-503) which amended UMTA to provide mass transit funding for urban and nonurban areas nationwide through block grants. Under the program, block grant money can be used for capital operating purchases at the localities' discretion. The act also requires transit authorities to reduce fares by 50 percent for the elderly and handicapped during offpeak hours. Also, passage of the Surface Transportation Assistance Act (STAA) of 1978 (P.L. 95-549) provided funding at the Federal level, known as the section 18 program, to support public transportation program costs, both operating and capital for nonurbanized areas. Elderly and handicapped people in nonurban and rural areas benefit significantly from section 18 projects because they generally are less mobile than other people and might be more isolated and in need of transportation assistance. Section 18 has received annual appropriations of approximately $65-$75 million since fiscal year 1979.

The STAA of 1982 (P.L. 97-424) established section 9 in its amendments to the UMTA Act. Section 9, a block grant program, replaces the former section 5 program (urban formula grants) and incorporates funding to continue the section 18 program. Section 9 provides assistance to the public in general, but some of its provisions are especially important to elderly and handicapped persons. Section 9 continues the requirement for recipients of Federal mass transit assistance to offer half-fares to the elderly and handicapped people during nonpeak hours. Each year, approximately $20 million in section 9 funds have been transferred to the section 18 program.

The programs administered by the Department of Health and Human Services have proven highly successful in providing limited supportive transportation services necessary for linking needy elderly and handicapped persons to social services in urban and suburban areas. The Department of Transportation programs have been the major force behind mass transit construction nationwide and continue to provide basic funding sources for primary transportation services for older Americans. Recognizing, nevertheless, the overlapping of funding and services, and the need for increased coordination, DHHS and DOT established an interdepartmental Coordinating Council on Human Services Transportation in 1986. The Council is charged with coordinating related programs at the Federal level and promote coordination at the State and local levels. As part of this effort, a regional demonstration project has been funded and transportation and social services programs in all States are being encouraged to develop better mechanisms for working together to meet their transportation needs.

Despite these program initiatives, however, Federal strategy in transportation remains essentially one of providing seed money for local communities to design, implement, and administer transportation systems to meet their individual needs and resources. In the future, the Federal response to the increasing need for specialized services for the elderly and handicapped will dictate the range of services available and, to a large extent, the fiscal responsibility of State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

2. ISSUES

(A) TRANSPORTATION AS ACCESS SERVICE

Medicare's Prospective Payment System (PPS) has placed increasing demands on transportation services. Under PPS, predetermined fixed payment rates are set for each Medicare hospital inpatient admission, based on the diagnosis-related group (DRG) into which that admission falls. This fixed payment is an incentive for hospitals to limit costs spent on Medicare patients either by reducing lengths of stay or the intensity of care provided. As a result, many older persons are being released from the hospital earlier and in need of more follow-up care than before the introduction of PPS. Consequently, State and area agencies on aging now are spending more of their transportation funds to transport older persons to dialysis and chemotherapy and less for grocery store and senior center transportation. One State (Kentucky), finding a statewide need for additional transportation services, particularly nonemergency services, characterizes transportation as its top priority. This same State conducted a survey which found that lack of transportation is a major barrier to mental health and social support services. Of those who had difficulty attending social activity programs, 52 percent cited the lack of transportation as the reason. This barrier results in less socialization and less satisfaction with life in general. In addition, it is anticipated that the demand for transportation services will increase.

TABLE 3.—LATENT DEMAND FOR TRANSPORTATION SERVICES OF POPULATION 65 AND OVER IN 2000

	Number of nondrivers	Trips per capita per year	Total annual trips
Urban		1,734.4	
Activity limitation			
Unable to conduct major activity	821,730		1,425,208,582
Limited in major activity	986,592		1,711,145,388
Limited but not in major activity	297,116		515,317,417
Unlimited	1,753,335		3,040,984,073
Suburban		1,734.4	
Activity limitation			
Unable to conduct major activity	1,211,704		2,101,578,756
Limited in major activity	1,454,805		2,523,214,312
Limited but not in major activity	438,120		759,874,835
Unlimited	2,585,426		4,484,162,956
Rural		1,679.3	
Activity limitation:			
Unable to conduct major activity	1,058,500		1,777,538,568
Limited in major activity	1,270,864		2,134,162,587
Limited but not in major activity	382,725		642,710,544
Unlimited	2,258,533		3,792,754,649
Total number of trips taken because of lack of transportation			24,908,652,616

Note: Table is based on high population projections for 2000.

Source: Calculated from the driving-loss model and derived from cohort-specific activity limitation rates and non-age-specific HIS data (49, 50), and mid-series population estimates (51). Also based on unpublished 1983 Nationwide Personal Transportation Study data.

The lack of adequate transportation to social activities, the grocery store and the doctor can have serious consequences for the well-being and independence of many elderly. It also may set back some of the advancements in health status across the country that have been achieved through better access to services.

(B) RURAL TRANSPORTATION NEEDS

Generally, Federal transportation policy has not recognized the specialized needs of rural elderly. In an effort to draw attention to these critical transportation issues, specific recommendations were made during the 1971 White House Conference on Aging directed at improving transportation for the rural elderly. A mini-conference on transportation for the aging which preceded the general conference recommended that State transportation agencies play a central role in developing responsive rural systems, with implementation for such a system initiated at the local level in order to ensure appropriate design for the unique needs of the individual community. The conference also recommended greater citizen participation at the policymaking level as well as at the advisory and implementation levels of transportation programs.

Transportation was cited as one of the major barriers facing the rural elderly in a 1984 report published by the Senate Special Committee on Aging. According to the report, an estimated 7 million to 9 million rural elderly lack adequate transportation, and as a result, are severely limited in their ability to reach needed services. Lack of transportation for the rural elderly stems from several factors. First, the dispersion of rural populations over relatively large areas complicates the design of a cost-effective, efficient public transit system. In addition, the incomes of the rural elderly generally are insufficient to afford the high fares necessary to support a rural transit system. Also, the rising cost of operating vehicles and inadequate reimbursement have contributed to the decline in the numbers of volunteers willing to transport the rural elderly. Further, the physical design and service features of public transportation, such as high steps, narrow seating, and unreliable scheduling, discourage participation.

Lack of access to transportation in rural areas leads to an underutilization of programs specifically designed to serve older persons, such as adult education, congregate meal programs, and health promotion activities. Thus, the problems of service delivery to rural elderly are essentially problems of accessibility rather than program design.

(C) SUBURBAN TRANSPORTATION NEEDS

The graying of the suburbs is a phenomenon which has only recently received attention from policymakers in the aging field. Since their growth following World War II, it has been assumed that the suburbs consisted mainly of young, upwardly mobile families. The decades that have elapsed since have changed entirely the profile of the average American suburb. The suburbs have aged with profound implications for social service design and delivery. In 1980, for the first time a greater number of persons over 65 lived in the suburbs (10.1 million) than in central cities (8.1 million).

This aging of suburbia can be attributed to two major factors. First, migration has contributed to the growth of the older suburban population. it is estimated that for every person age 65 and older who moves back to the central city, three move from the central city to the suburbs. Second, there is the desire of many older persons to remain in the homes and neighhborhoods in which they have grown old, i.e., "aging in place." The growth of the suburban elderly is expected to continue to increase at an even more rapid rate in the future due to the large number of so-called pre-elderly (ages 50-64) living in the suburbs.

A 1988 national study conducted by the U.S. Conference of Mayors (USCM) and the National Association of Counties (NACo) of the 260 Metropolitan Statistical Areas identified three priority concerns of the suburban elderly: Home and community-based care, housing, and transportation. The availability of transportation services for the elderly suburban dweller is limited. Unlike large cities where dense population patterns can facilitate central transit systems, the lack of a cental downtown precludes development of a coordinated mass transit system in most suburbs. The sprawling geographical nature of suburbs makes the cost of developing and operating mass transportation systems prohibitive. Private taxi companies, if they operate in the outlying suburban areas at all, are usually very expensive. Further, the trend toward retrenchment and fiscal restraint by the Federal Government has impacted significantly on the development of transportation services generally. Consequently, Federal support for primary transit systems designed especially for the elderly suburban dweller is almost nonexistent, and consists mostly as a supportive service. State and local governments have been unable to harness sufficient resources to fund costly transportation systems independent of Federal support. Often, alternative revenue sources are not politically expedient. For example, user fees alone are insufficient to support suburbanwide services and are generally viewed as penalizing those most in need of transportation services in the community—the elderly poor.

The aging of the suburbs has several implications for transportation policy and the elderly. The dispersion of older persons over a suburban landscape poses a challenge for community planners who have specialized in providing services to younger, more mobile dwellers. Transportation to and from service providers is a particularly critical need. Institutions that serve the needs of elderly persons, such as hospitals, senior centers, and convenience stores, necessarily must be designed with supportive transportation services in mind. In addition, service providers must provide transportation services for their elderly clients. Primary transportation systems, or mass transit, must ensure accessibility from all perimeters of the suburban community to adequately serve the dispersed elderly population. The demand for transportation services should be measured to determine the feasibility of alternative systems, such as dial-a-ride and van pools. Alternative funding mechanisms, such as reduced fares, user fees, and the local tax base, need to be examined for equity and viability. Also, the public should be informed of the transportation services available through a coordinated public information network within the community.

The aging suburb trend will increase in the decades to come. It is clear that to the degree that the elderly are denied access to transportation, they are denied access to social services. If community services are to meet the growing social and economic needs for the older suburban dweller, transportation planning and priorities will demand re-examination.

(D) SAFETY

The automobile remains the primary means of meeting the mobility needs of the entire country, including older persons. More than 80 percent of trips by persons age 65 and over are made in automobiles and that percentage is increasing.

A 1988 study by the Transportation Research Board (TRB) on the mobility and safety of older drivers found that up through age 75, most older drivers have good driving records and appear to perform as well as middle-aged ones. However, although they are involved in a small number of crashes, after age 75, older drivers are about twice as likely to be involved in a crash per mile driven. In addition, older persons are among the most vulnerable to injury in motor vehicle crashes. Automobile occupants 65 and older are more than three times more likely to die than a 20-year-old occupant from serious injuries of equal severity. The study emphasis that as age is not a predictor of performance, age alone should not be the basis for restricting or withholding driver's licenses.

The TRB report does recommend changes in roadway design and operation to improve the safety of not only older but all drivers. For example, current sign legibility standards assume a level of visual ability that many older persons cannot meet. Safety could be enhanced by larger and brighter road signs.

Walking is second in importance to driving as a mode of transportation for older persons. For those older persons without driver licenses, between 20 and 40 percent of all their trips are made by walking. Yet the suburban environment, in particular, does not provide for safe walking—pedestrian crossings are frequent not available and signals are set to maintain a high volume of through auto traffic. In addition, signal timing assumes a walking speed faster than that of many older pedestrians.

3. Federal and State Responses

(A) FEDERAL

Congress enacted no major transportation authorization legislation in 1989. However, the Americans With Disabilities Act, which passed the Senate, contained numerous provisions affecting local transportation systems. Of particular importance is a section requiring local transportation systems to make existing services accessible and to provide paratransit services, where feasible.

The appropriations bill for fiscal year 1990 (P.L. 101-164) appropriated $34.9 million for elderly and handicapped projects, and innovative research programs, authorized under the Federal Mass Transportation Act of 1987.

In 1990, there may be significant developments in transportation programs affecting the elderly and disabled. First, the House may pass the Americans with Disabilities Act, which would greatly expand elderly and handicapped persons' access to transportation services. Second, Transportation Secretary Samuel Skinner has invited public discussion of a national transportation policy that may address access issues critical to older Americans.

(B) STATES

As an indication of concern about transportation issues, the Council of State Governments created the Center for Transportation in 1986 to function as a State policy research think-tank. A survey by the Center reveals that at least 40 States have responded to the issue of coordination of locally designed services by creating either voluntary or legislatively mandated interagency coordination committees. In addition, nine States impose mandatory coordination on local providers.

Montana, for example, has developed an interagency coordination approach for purchasing vehicles. As the lead agency, the Department of Commerce works to ensure that vehicles are shared by those agencies that need them at the local level. Local technical advisory committees also review and recommend applications for transportation providers and purchasers of services in the community, including the area agencies on aging. In Florida, the Coordinating Council for the Transportation Disadvantaged oversees and develops policy on issues that affect about 4 million elderly, low-income, and handicapped residents who need transportation assistance. Approximately $41 million is being spent for these services in all 67 counties of the State. Each county has designated a single provider to coordinate these services.

E. LEGAL SERVICES

1. Background

(A) THE LEGAL SERVICES CORPORATION

Legislation creating the Legal Services Corporation (LSC) was enacted in 1974. Previously, legal services had been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act in 1966. Because litigation initiated by legal services attorneys often involves local and State governments, or controversial social issues, legal services programs can be subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, the Nixon Administration developed legislation creating a separate, independently housed corporation. The Legal Services Program then was established as a private, nonprofit corporation headed by an 11 member board of directors, nominated by the President and confirmed by the Senate.

LSC does not provide legal services directly; rather, it funds local legal aid projects. Each local legal service project is headed by a board of directors, of which 60 percent are lawyers who have been admitted to a State bar.

Legal services provided through LSC funds are available only in civil matters and to any individual with an income no higher than 125 percent of the Office of Management and Budget poverty guidelines. LSC places primary emphasis on the provision of routine legal services and the majority of LSC-funded activities involve routine legal problems of low-income people. According to the most recent report of the Corporation in 1985, almost one-third of legal services cases are family related, such as divorce and separation, child custody and support, and adoption. Another 19 percent of legal services cases deal with housing problems, primarily landlord-tenant disputes in nongovernment subsidized housing. Problems with welfare or other income maintenance programs, and consumer and finance problems, form the next two largest categories of legal services cases. Individual rights, employment, health, juvenile, and education cases make up the remaining caseload. Most cases are resolved outside the courtroom. LSC attorneys do their primary representation of the elderly in Government benefit programs such as Social Security and Medicare.

LSC funds 23 national and State support centers, which develop and provide specialized expertise in various aspects of poverty law to legal services attorneys in the field. Three of these centers are involved specifically in issues that confront older people: the National Senior Citizens Law Centers, in Los Angeles and Washington, DC; and Legal Counsel for the Elderly, in Washington, DC. In addition, LSC currently is funding 27 law school clinical programs to assist eligible clients during the academic year 1988-89.

Several restrictions on the types of cases legal services attorneys may handle were included in the original and several others have been added since then. Most of the restrictions were made in response to critics of the program who charge that legal services funds have been used to promote the social and political goals of activist attorneys under the guise of providing legal assistance to the poor. Opponents believe that although legal services attorneys theoretically are prohibited from pursuing their own political and social intersts by a requirement that they represent a particular client before getting involved in an issue, this requirement easily is circumvented without specific restrictions. Current regulations include a prohibition on cases dealing with school desegregation, nontherapeutic abortions, certain violations of the Selective Service Act, and Armed Forces desertion. The fiscal year 1987 appropriations measures (P.L. 99-500-99-591) contained additional prohibitions against lobbying with Corporation funds, representing aliens who do not meet specified conditions, and class action suits against Federal, State, or local governments except under certain circumstances.

Other restrictions were promoted by supporters of legal services who were concerned that the broad scope of the Corporation's work would be curtailed sharply by its detractors. For example, the 1987 appropriations measures also require prior notification of Congress when regulations are to be promulgated. This notification requirement was added in response to concerns that proposed regulations issued by the LSC, such as those curtailing legislative and administrative advocacy by LSC attorneys on behalf of poor clients, would change drastically existing Corporation policy.

In the fiscal year 1990 appropriations measure (P.L. 101-162), Congress retained all prior restrictions and prohibited the LSC from imposing its own additional requirements on governing boards of recipients of LSC grants.

(B) OLDER AMERICANS ACT

Support for legal services under the Older Americans Act (OAA) was a subject of interest to both the Congress and the Administration on Aging (AoA) for several years preceding the 1973 amendments to the OAA. There was no specific reference to legal services in the initial version of the OAA in 1965, but recommendations concerning legal services were among those made at the 1971 White House Conference on Aging. Regulations promulgated by the AoA in 1973 made legal services eligible for funding under Title III of the OAA. Subsequent reauthorizations of the OAA contained provisions relating to legal services. In 1975, amendments granted legal services priority status. Amendments to the OAA, in 1978, established a funding mechanism and a programmatic structure for legal services. The 1981 amendments required area agencies on aging to spend "an adequate proportion" of legal service funding for three categories, including legal services as well as access and in-home services, and that "some funds" be expended for each service. The 1984 amendments to the Act retained the priority, but changed the term to "legal assistance," and required as well that an "adequate proportion" be spent on "each" priority service. In addition, area agencies were to annually document funds expended for this assistance.

A survey by the Center for Social Gerontology in Michigan prior to the 1987 reauthorization of the Act, found that 40 States had no specific policy or definition of "adequate proportion" for each of the priority services. Consequently, the 1987 amendments specified that each State unit on aging must designate a "minimum percentage" of Title III social services funds which area agencies on aging must devote to legal assistance and the other two priority services. If an area agency expends at least the minimum percentage set by the State, it will have fulfilled the adequate proportion requirement. Congress intended the minimum percentage to be a floor, not a ceiling, and encouraged area agencies to devote additional funds to each of these service areas to meet local needs.

In addition, the Act also requires that area agencies contract with legal services providers who can demonstrate the experience or capacity to deliver legal assistance and to involve the private bar in their efforts. If the legal assistance grant recipient is not also a LSC grantee, coordination with LSC-funded programs is required.

Another mandate under the OAA requires State agencies on aging to establish and operate a long-term care ombudsman program to, among other things, investigate and resolve complaints made by or on behalf of residents of long-term care facilities. The 1981 amendments to the OAA expanded the scope of the ombudsman program to include board and care facilities. The 1987 amendments require States to ensure ombudsmen protection from liability, willful interference, and retaliation in the good faith performance of their duties. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs.

The AoA has stressed the importance of such a relationship and has provided grants to States designed to further ombudsman, legal, and protective service activities for older people and to assure coordination of these activities. State ombudsman reports and a survey by the American Association of Retired Persons in 1987 indicate that through both formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to facilities, residents, and residents' records; provide consultation to ombudsman programs on law and regulations affecting institutionalized persons; represent clients referred by ombudsman programs, and work with ombudsmen and others to bring about changes in policies, laws, and regulations which benefit older persons in institutions.

In other initiatives under the OAA, the Administration on Aging (AoA) began in 1976 to fund State legal services developer positions—attorneys, paralegals, or lay advocates—thorugh each State unit on aging. These specialists work in each State to identify interested participants, locate funding, initiate training programs, and assist in designing projects. They work with legal services offices, bar associations, private attorneys, paralegals, elderly organizations, law firms, attorney generals, and law schools. The 1984 amendments to the Older Americans Act required States to fund this position.

In addition, the 1984 amendments also mandated that the AoA fund national legal support centers. Through grants and contracts, AoA currently supports the National Senior Citizens Law Center; Legal Counsel for the Elderly (sponsored by the American Association of Retired Persons); the ABA's Commission on Legal Problems of the Elderly, all in Washington, DC; and the Center for Social Gerontology in Michigan.

Today, OAA moneys support over 600 legal programs for the elderly in the greatest social and economic need. Unfortunately, the amount of Title III funds expended on legal services for recent fiscal years is not available. As part of its past efforts to reduce State reporting burdens, AoA discontinued the requirement that States report expenditure data on types of services. According to the AoA fiscal year 1987 Program Performance Report, about 458,000 older persons received legal services. The 1987 amendments to OAA, however, requires that beginning in fiscal year 1989, the Commissioner collect data on funds expended on each type of service, as well as the number of persons who are recipients of such sevices and the number of units of services provided. These data are to be collected annually.

(C) SOCIAL SERVICES BLOCK GRANT

Under the block grant program, Federal funds are allocated to States which, in turn, provide services directly or contract with public and nonprofit social service agencies for providing social services to persons and families. For the most part, States determine which social services to provide and for whom they shall be provided. Services may include legal aid. Because the Omnibus Budget Reconciliation Act of 1981 eliminated much of the reporting requirements previously included in the Title XX program, little information is available on how States have responded to both funding reductions and changes in the legislation. As a result, there is no information available on the number of persons or the age breakdown of those persons who are being served.

2. Issues

(A) NEED AND AVAILABILITY OF LEGAL SERVICES

The need for civil legal services for the elderly, especially the poor elderly, is undeniable. This is partially due to the complex nature of the programs upon which the elderly are dependent. After retirement, most older Americans rely on Government-administered benefits and services for their entire income and livelihood. For example, many elderly persons rely on the Social Security Program for income security and on the Medicare and Medicaid Programs to meet their health-care needs. These benefit programs are extremely complicated and often difficult to understand.

In addition to problems with Government benefits, older persons' legal problems typically relate to consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to an institution, nursing home, and probate matters. Legal services and professional legal representation are of vital importance to the elderly because they help them obtain basic necessities and assure that they receive benefits and services to which they are entitled.

Legal Services Corporation programs do not necessarily specialize in serving older clients but do attempt to meet the legal needs of the poor of which the elderly are a significant proportion. Legal services provided by LSC attorneys are given to people based on financial needs. Eligibility is based on incomes up to 125 percent of the established poverty level. It is estimated that approximately 9 million persons over 60 are LSC-eligible.

There is no precise way of determining eligibility for legal services under the Older Americans Act since eligibility is based on both economic and social need, and means testing for eligibility is prohibited. Nevertheless, a White Paper developed by several legal support centers in 1987 demonstrated that, in spite of advances in the previous 10 years, the need for legal assistance by older persons is much greater than available Older Americans Act resources can meet.

The availibility of legal representation for low-income older persons is determined, in part, by the availability of funding for legal services programs. In recent years, there has been a trend to cut back the flow of Federal dollars to local programs for the delivery of elderly legal services and there is no doubt that older persons are finding it more difficult to obtain legal assistance. When the LSC was established in 1975, its foremost goal was to provide all low-income people with at least "minimum access" to legal services. This was defined as the equivalent of 2 legal services attorneys for every 10,000 poor people. The goal of minimum access was achieved in fiscal year 1980 with an appropriation of $300 million, and in fiscal year 1981 with $321 million. This level of funding met only an estimated 20 percent of the poor's legal needs. Currently, however, the LSC is not funded to provide even minimum access to legal assistance for poor persons. In most States, there is only 1 attorney for every 10,000 poor persons. In contrast, there are approximately 28 lawyers for every 10,000 persons above the Federal poverty line.

The Private Attorney Involvement (PAI) project under LSC requires each LSC grantee to spend at least 12.5 percent of its basic field grant on the direct delivery of legal services by private attorneys (as opposed to LSC staff attorneys). The funds have been primarily used to develop pro bono panels, with joint sponsorship between a local bar association and a LSC grantee. Over 350 programs currently exist throughout the country. LSC states that data indicates that the PAI requirement is an effective means of leveraging funds, closing a higher percentage of cases per $10,000 of funding with PAI dollars than with dollars supporting staff attorneys.

It should be noted, however, that these programs have been criticized by legal services staff attorneys. They claim that they have been unjustifiably cited to support less LSC funding and to divert cases from LSC field offices.

In fiscal year 1982, Congress reduced funding to the LSC by 25 percent (from $321 million to $241 million), resulting in the immediate loss of 1,793 attorneys and the closing of more than 108 local offices, making it more difficult for older persons with legal needs to gain access to legal representation. In fiscal year 1988, there was 324 legal services programs in the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam. The number of field program offices in 1988 was approximately 1,150, down from 1,475 in 1981. At the end of 1987, the LSC employed 4,767 attorneys, as compared to 6,559 in 1980.

LSC programs handled and closed 1,421,805 cases in fiscal year 1988. About 13 percent of the cases handled in 1988 involved a client age 60 or older.

Cuts in funding has also meant a decrease in the LSC's ability to meet client's legal needs. Legal services field offices report having to scale down their operations and narrow their priorities to focus attention on emergency cases, such as evictions or loss of means of support. Legal services offices must not make hard choices about which poor person will be denied service and which will receive legal attention.

An essential component of legal services delivery systems for the elderly is the private bar. The expertise of the private bar is considered especially important in areas such as wills and estates as well as real estate and tax planning. Many elderly persons cannot obtain legal services because they cannot afford to pay customary legal fees. In addition, a substantial portion of the legal problems of the elderly stem from their dependence on public benefit programs. The private bar generally is unable to undertake representation in these matters because it requires familiarity with a complex body of law and regulations, with little chance of generating a fee for services rendered. Although many have cited the capacity of the private bar to meet some of the legal needs of the elderly on a full-fee, low-fee, or no-fee basis, the potential of the private bar to serve the elderly in need of legal assistance has not yet been fully realized.

(B) LEGAL SERVICES CORPORATION

(1) Board Appointments

During the Reagan Administration, there was continuing conflict between the White House and the Congress over appointees to the LSC's board of directors. During the summer of 1981, the terms of all 11 LSC board members appointed by former President Carter expired. President Reagan, however, did not name any new members of the board until December 1981, after it became apparent that his proposal to terminate the Corporation would not be accepted. Between 1981 and 1984, he nominated a succession of people to the board on an interim basis. Because there appointments were made while Congress was in recess, they could serve without any Senate confirmation. During the same period, President Reagan announced a number of prospective nominees, but none was confirmed by the Senate. Some of them were opposed by liberals and moderates who questioned their qualifications and their commitment to legal services to the poor. Reports in 1982 that LSC board members were receiving extraordinarily large consulting fees for their services and that the LSC president was given unusually generous fringe benefits further affected the nomination process. In 1984, President Reagan granted recess appointments to 11 individuals he had unsuccessfully nominated earlier in the year. These people served without Senate confirmation until the end of 1985. The names of these individuals, however, also were resubmitted formally to the Senate on January 3, 1985, when the Congress convened. Although a couple of the nominees were controversial and faced stiff opposition, all were approved by the Senate Labor and Human Resources Committee and subsequently by the full Senate on June 12, 1985.

The controversy over appointments to the LSC board continued in 1989. Although the terms of all board members expired in 1988, President Bush failed to submit any nominees to the Senate for confirmation during his first year in office. In the fall, board member Pepe Mendez resigned, and the term of Reagan recess appointee J. Blakely Hall expired. Without these two members, the moderate bloc of the board held a slight 5-4 majority, and many predicted that it would act to oust longtime LSC president Terrance Wear. However, on November 30, President Bush granted J. Blakely Hall a second recess appointment and appointed John Erlenborn, a former Illinois Congressman, to Mendez' seat. The board then voted 6-5 against removing Wear from his position. Mr. Wear's position with LSC may remain an issue in 1990.

(2) Elimination of Legal Services Corporation

Few people disagree that provision of legal services to the elderly is important and necessary. However, people continue to debate how to best provide these services. In 1981, President Reagan proposed to terminate the federally funded LSC and to include legal services activities in a social services block grant. Funds then going to the Corporation, however, were not proposed for inclusion in the block grant. The block grant approach was consistent with Reagan Administration's goal of consolidating categorical grant programs and transferring decisionmaking authority to the States. Inclusion of legal services as an eligible activity in block grants, it was argued, would give States greater flexibility to target funds where the need is greatest and that allowing States to make funding decisions regarding legal services would make the program accountable to elected officials.

At the time of this proposal, the Reagan Administration revived earlier charges that legal services attorneys are more devoted to social activism and to seeking collective solutions and reform than to routine legal assistance for low-income individuals. These charges resparked a controversy surrounding the program at the time of its inception as to whether Federal legal aid is being misused to promote liberal political causes. The poor often share common interests as a class, and many of their problems are institutional in nature, requiring institutional change. Because legal resources for the poor are a scarce commodity, legal services programs have often taken group-oriented case selection and litigation strategies as the most efficient way to vindicate rights. The use of class action suits against the Government and businesses to enforce poor peoples' rights has angered some officials. Others protest against the use of group orientation methods on the basis that the poor can be protected only by allocation and litigation procedures which treat each poor person equally as a unique individual and not by procedures which weigh group impact. As a result of these charges, the ability of legal services attorneys to bring class action suits has been severely restricted.

Former President Reagan also justified his proposal to terminate the LSC by stating his belief that added pro bono efforts by private attorneys could substantially augment legal services funding provided by the block grant. The administration noted that elimination of restrictions on advertising by attorneys would increase the availability of low-cost legal services. They pointed to a congressionally mandated study which found legal services provided by private attorneys to be as effective as those provided by staff attorneys hired directly by local legal services programs. Their approach would allow States to choose among a variety of service delivery mechanisms, including reimbursement to private attorneys, rather than almost exclusive use of full-time staff attorneys supported by the LSC. Finally, the administration argued that regardless of the continued existence of LSC, some funding is available at the State and local level for civil legal assistance to truly needy individuals.

The Chairman of the Board of Directors of LSC, in a speech before the ABA's Board of Governors in 1987, also called for the elimination of the LSC. In its place he suggests a system of lay advocates to deliver services to the poor. He maintains that bar associations, motivated by self-interest, prevent more widespread use of paraprofessionals and lay advocates. Opponents of this proposition, including Members of Congress, point out that the founding principle of the LSC was that the poor should have access to professional legal services provided by attorneys.

Supporters of federally funded legal services programs argue that neither State nor local governments nor the private bar would be able to fill the gap in services created by abolition of the LSC. They cite the inherent conflict of interest and the State's traditional nonrole in civil legal services which, they say, makes it unlikely that States will move forward to provide effective legal services to the poor. Many feel that the voluntary efforts of private attorneys cannot be relied on, especially when more lucrative work beckons. They believe that private lawyers have limited desire and ability to do volunteer work. Some feel that, in contrast to the LSC lawyers who have expertise in poverty law, private lawyers are not as likely to have this experience nor are they as likely to have the interest in dealing with the systematic abuses that poor people encounter.

Defenders of LSC say that the need among low-income people for civil legal assistance exceeds the level of services currently provided by both the LSC and the private bar. Elimination of the Corporation and its funding could further impair the need and the right of poor people to have access to their government and to the whole system of justice. They contend that it is also inconsistent to assure low-income people representation in criminal matters, but not to provide them with legal assistance in civil cases.

In 1989, President Bush made few public statements regarding the LSC. However, his failure to aggressively fight inclusion of the LSC in fiscal 1990 appropriations legislation may indicate his intention to support the continued existence of the LSC.

(3) Elimination of Support Centers

The Reagan Administration also attempted to cut off funds to the national and State legal services support centers as well as for computer assisted legal research, the clearinghouse, and the network of programs designed to aid migrant workers.

At a meeting in October 1987, the LSC board approved 6-5 a motion for the cutoff. In the Senate an effort was made to implement LSC's intent in the form of an amendment to the appropriations continuing resolution. However, the Senate viewed the LSC proposal as an attempt to change the structure of the LSC, instituting in its place a voucher system, and soundly defeated the proposed amendment by a 70-28 vote. It was pointed out during Senate debate that the 17 national support center staffs provide the only in-depth coverage of issues of special importance to poor people—affordable health care and housing, Social Security, consumer problems, welfare, and employment—and, are expert in the interpretations of regulations, statutes, administrative and legislative procedures in these areas.

In 1988, President Reagan, in an appendix to his State of the Union message to Congress, stated his support of actions ensuring that grantees are involved in individual cases and not broader "law reform" activities. The administration did not request any funding for support centers although for the first time, it did request some funding for LSC. The LSC, in a revised budget request to match that of the administration's, justified eliminating the support centers in order to guarantee local control of limited LSC funds.

In a survey of legal services program directors conducted by the LSC itself, 90 percent urged the continuation of national support centers rather than a proportional increase in their own program funding. The $7.2 million that goes to national support centers would provide less than a 3-percent increase for each field program, an increase so small that it would not fill the gap that would be created by the loss of specialized assistance.

(4) Lobbying

In 1988, a dispute arose over the use of LSC funds for the purpose of lobbying Congress. Former President Reagan, for the first time during his tenure, requested funding for the Legal Services Corporation for fiscal year 1989 at an amount lower than the fiscal year 1988 appropriation. Although the Corporation had initially requested the same funding as fiscal year 1988, the Board of Directors, in a 6-5 vote, decreased its budget request to match that of the administration.

The Corporation then briefly engaged the services of three Washington law firms to lobby Congress for the decrease. An immediate outcry from Congress led the Corporation to rescind its agreements with the law firms, although the Chairman of the Board of Directors of LSC maintained that the prohibition on lobbying Congress by LSC did not apply to law firms retained by the LSC. An opinion by the Comptroller General on the issue, however, held that the retention of law firms to influence Congress to reduce LSC's appropriations is contrary to the law. A resolution was introduced in the Senate calling for the Corporation chairman's resignation. Bitterness over LSC lobbying continues to linger in Congress.

3. Federal and Private Sector Response

(A) LEGISLATION

(1) The Legal Services Corporation

The 1974 LSC Act was reauthorized for the first and only time in 1977 for an additional 3 years. At that time, much of the controversy surrounding the program, which grew from a perception that the program was one of social activism and reform rather than routine legal assistance, had abated. Since the early 1980's, however, the controversy as to whether Federal legal aid money is being misused to promote liberal political causes has re-emerged. This is due, in part, to the fact that for fiscal years 1981-88, the Reagan Administration has announced plans not to seek reauthorization of the program and has requested no funding for it. Congress, however, has rejected these proposals and has responded with bipartisan support to restore funding.

Funding for the LSC in its first year was $92.3 million. It rose to its highest level of $321.3 million in fiscal year 1981. In fiscal year 1982, funding for the Corporation was cut by 25 percent to $241 million. Since then, funding for LSC has been at a reduced level.

Although President Reagan requested no funding for the Legal Services Corporation for fiscal years 1981-88 and the legislation authorizing the LSC expired at the end of fiscal year 1980, the agency has operated under a series of continuing resolutions and appropriations bills, which have served both as authorizing and funding legislation. The Corporation is allowed to submit its own funding requests to Congress. In fiscal year 1985, Congress began to earmark the funding levels for certain activities to ensure that congressional recommendations were carried out. In addition to original restrictions, the legislation for fiscal year 1987 included language directing that provisions regarding legislative and administrative advocacy in previous appropriations bills and the Legal Services Corporation Act of 1974, as amended, shall be the only valid law governing lobbying and shall be enforced without regulations. This language was included because the Corporation published proposed regulations which were believed to go far beyond the restrictions on lobbying which are contained in the LSC statute.

For fiscal year 1988, Congress appropriated $305.5 million for the LSC. Congress also directed the Corporation to submit plans and proposals for the use of funding at the same time it submits its budget request to Congress. This was deemed necessary because the appropriations committees had encountered great difficulty in tracing the funding activities of the Corporation and received very little detail from the Corporation about its proposed use of the funding request, despite repeated requests for information.

The fiscal year 1988 appropriations bill also included a legislative formula governing the allocation of funds for grants and contracts among the basic field programs. In addition, the Corporation is prohibited from imposing requirements on the governing bodies of recipients of LSC grants that are additional to, or more restrictive than, provisions already in the LSC statute. This provision includes the procedures of appointment, including the political affiliation and length of terms of office of members, and the size, quorum requirements, and committee operations of the governing bodies.

Congress appropriated $321 million for LSC in fiscal year 1990, earmarking almost $275 million for basic field programs and $7.5 million for national support centers. Provisions effective in fiscal year 1990 that are continued from past years' appropriations include restrictions on lobbying, class action suits, representation of aliens, language requiring prior notification of the Congress when regulations are to be promulgated. Restrictions concerning governing bodies of recipient programs and LSC enforcement of legislative and administrative advocacy containment will expire upon confirmation by the Senate of a board of directors who are nominated by President Bush.

It is difficult to predict what Federal action will be taken with respect to LSC in 1990. Many advocates and Members of Congress are waiting to see whether President Bush will nominate a new board of directors before any legislative initiatives are contemplated.

(2) Older Americans Act

In response to prior conflict between legal assistance providers and area agency staff on confidentiality and reporting, the 1987 amendments to the Older Americans Act (OAA) (P.L. 100-175) specifically provides that State and area agencies may not require Title III legal providers to reveal information that is protected by the attorney-client privilege.

The OAA 1987 amendments also require the State agency to establish a minimum percentage of Title III B funds which each area agency must spend on legal services and requires the area agencies to spend an adequate proportion of the funds on legal services, defined as the minimum percentage established by the State agency. In addition, prior to granting a waiver of this requirement, the State agency must provide a 30-day notice period during which individuals or providers may request a hearing, and offer the opportunity for a hearing to any individual or provider who makes such a request. The conference report on the Act's amendments states that the minimum percentage is intended to be a floor, not a ceiling. Area agencies on aging are encouraged to devote additional funds to legal services, as well as access and in-home services, to meet local needs.

Four national organizations have continued to receive funding from the Administration on Aging in 1988 to support legal services activities: Legal Counsel for the Elderly (sponsored by the American Association of Retired Persons); the American Bar Association's Commission on Legal Problems of the Elderly; the Center for Social Gerontology; and the National Senior Citizens Law Center. In addition, in 1988, the Administration on Aging awarded grants to three additional national legal service organizations to work with States and area agencies on aging to help vulnerable older individuals with legal problems.

Although no congressional action regarding OAA-funded legal services is expected in 1990, several committees may begin holding hearings and conferences on this subject.

(B) ACTIVITIES OF THE PRIVATE BAR

To counter the effects of cuts in Federal legal services and to ease the pressure on overburdened legal services agencies, some law firms and corporate legal departments have begun to devote more of their time to the poor on a pro bono basis. These programs are in conformity with the lawyer's code of professional responsibility which requires every lawyer to support the provision of legal services to the disadvantaged. While such programs are gaining momentum, there is no precise way to determine the number of lawyers actually involved in the volunteer work, the number of hours donated, and the number of clients served. Most lawyers for the poor say that these efforts are not yet enough to fill the gap and that a more intensive organized effort is needed to motivate and find volunteer attorneys.

A recent development in the delivery of legal services by the private bar has been the introduction of the Interest on Lawyers' Trust Accounts (IOLTA) program. This program allows attorneys to pool client trust deposits in interest bearing accounts. The interest generated from these accounts is then channeled into federally funded, bar affiliated, and private and nonprofit providers of legal services. IOLTA programs have grown rapidly—there was one operational program in 1983, today 47 States and the District of Columbia have adopted IOLTA programs that are bringing in funds at a rate of $42 million per year. The Legal Services Corporation reported receiving $29 million through IOLTA in 1988. An American Bar Association study group estimated that if the plan was adopted on a nationwide basis, it could produce up to $100 million a year. The California IOLTA program specifically allocates funds for those programs serving the elderly. Although many of the IOLTA programs are voluntary, the ABA, passed a resolution at the February 1988 meeting suggesting that IOLTA programs be mandatory in order to raise funds for charitable purposes.

Supporters of the IOLTA concept believe that there is no cost to anyone with the exception of banks, which participate voluntarily. Critics of the plan contend that it is an unconstitutional misuse of the money of paying client who is not ordinarily apprised of how the money is spent. To this argument, supporters point out that attorneys and law firms have traditionally pooled their client trust funds, and it is difficult to attribute interest to any given client. Prior to IOLTA, the banks have been the primary beneficiaries of the income. While there is no unanimity at this time among lawyers regarding IOLTA, it appears to have potential value as a needed funding alternative.

In 1977, the president of the ABA was determined to add the concerns of senior citizens to the ABA's roster of public service priorities. He designated a task force to examine the status of legal problems and the needs confronting the elderly and to determine what role the ABA could play. Based on a recommendation of the task force, an interdisciplinary Commission on Legal Problems of the Elderly was established by the ABA in 1979. The Commission is charged with examining six priority areas: The delivery of legal services to the elderly; age discrimination; simplification of administrative procedures affecting the elderly; long-term care; Social Security; and housing. Since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

The Commission has undertaken many activities to promote the development of legal resources for older persons and to involve the private bar in responding to the needs to the aged. One such activity was the national bar activation project which provided technical assistance to State and local bar associations, law firms, corporate counsel, legal service projects, the aging network, and others in developing projects for older persons.

The private bar has also responded to the needs of elderly persons in new ways on the State and local levels. Currently, there are 35 State and 12 local bar association committees on the elderly. Their activities range from legislative advocacy on behalf of seniors and sponsoring pro bono legal services for elderly people, to providing community legal education for seniors. Nearly 50 State and local projects utilize private attorneys to represent elderly clients on a reduced fee or pro bono basis. In more than 38 States, handbooks which detail seniors' legal rights have been produced either by State and area agencies on aging, legal services offices, or bar committees. In addition, some bar associations sponsor telephone legal advice lines. Since 1982, attorneys in more than half the States have had an opportunity to attend continuing legal education seminars regarding issues affecting elderly people. The emergence of training options for attorneys that focus on financial planning for disability and long-term care are particularly noteworthy.

In 1987, the Academy of Elder Law Attorneys was formed. The purpose of this organization is to assist attorneys advising elderly clients, to promote high technical and ethical standards, and to develop awareness of issues affecting the elderly.

A few corporate law departments also have begun to provide legal assistance to the elderly. For example, Aetna Life and Casualty developed a pro bono legal assitance to the elderly program in 1981 through which its attorneys are granted up to 4 hours a week of released time to provide legal help for eligible older persons. In 1987, 20 Aetna attorneys participated in the program, handling over 140 cases. The Ford Motor Company Office of the General Counsel began a project in 1986 to provide pro bono representation to clients referred by the Detroit Senior Citizens Legal Aid Project.

As recognized by the ABA, private bar efforts alone fall far short in providing for the needs of older Americans for legal help. The ABA has consistently maintained that the most effective approach for providing adequate legal representation and advice to needy older persons is through the combined efforts of a continuing LSC, and effective OAA program, and the private bar. With increased emphasis on privat bar involvement, and with the necessity of leveraging resources, the opportunity to design more comprehensive legal services programs for the elderly exists.

Chapter 13

FEDERAL BUDGET

OVERVIEW

Following his inauguration in January 1989, President Bush pledged that he would stive for compromise and conciliation with Congress in reaching decisions involving the fiscal year 1990 budget. With the Gramm-Rudman-Hollings deficit reduction target for fiscal year 1990 set at a difficult to reach $100 billion, both the President and Congress appeared to have strong incentives to produce a budget agreement that avoided the automatically triggered sequestration, with its across-the-board and potentially damaging reductions.

On April 14, 1989, the White House and leaders of Congress announced a "Bipartisan Budget Agreement." The Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) both projected a final deficit for fiscal year 1990 of $99.4 billion, provided that all provisions of the agreement were implemented. The congressional budget resolution for fiscal year 1990 adopted on May 18, reflected adherence to the April agreement. However, full accomplishment of the provisions also depended upon passage of a reconciliation measure (along with actions on the 13 regular appropriations bills).

While the normal deadline for acting on reconciliation is supposed to be June 15, final congressional action on the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239) did not occur until late fall. Final action did not come about largely due to a major and drawn-out dispute between the President and the congressional leadership over President Bush's capital gains proposal. This proposal would reduce the tax burden on primarily well-to-do citizens by reducing the amount of taxes they pay when they sell property or other capital assets.

President Bush argued that his capital gains approach would provide additional incentives to sell capital and reinvest earnings into the economy, thereby replacing and increasing the lost revenue from the tax incentive. Senator Mitchell, the Senate Majority Leader, and Congressman Foley, the Speaker of the House, argued that the windfall that wealthy Americans would receive and the limited amount of reinvestment that would occur did not justify the tax cut.

Following months of heated debate over the capital gains proposal, as well as a moderately successful attempt to "strip-down" a budget reconciliation measure that the majority of the Senate concluded was overly replete with "extraneous" provisions, the Congress passed the reconciliation bill on November 22, 1989. This act implemented various provisions of the April agreement, as well as complying with the fiscal year 1990 budget resolution, with a deficit reduction package tagged at $14.7 billion in savings.

Since the reconciliation package was not in place by mid-October, the President issued the final sequestration order for fiscal year 1990 on October 16. This order resulted in uniform reductions of $8.05 billion each in defense and nondefense spending. OBRA 1989 retained about a third of the original sequestration cuts (for a savings of $4.55 billion in fiscal year 1990), and provided for the rescission of the October order upon issuance of a revised report and sequester order. The revised report was released on December 27, 1989, and, according to sequestration calculations, the revised deficit reduction figure for Fiscal Year 1990 called for a uniform reduction percentage of 1.5 percent in defense programs and 1.4 percent in nondefense programs.

With regard to appropriation actions, development relating to the Federal budget process in 1989 for the second year in a row reflected the "return to normalcy." Following 2-years of omnibus continuing resolutions, in the fall of 1987, Congress completed action on all 13 regular appropriations bills before the start of the new fiscal year on October 1. In 1989, Congress succeeded in passing all 13 bills before Thanksgiving, but three short-term continuing resolutions proved necessary to fund the Government from the start of the new fiscal year on October 1 until November 22, when the President signed the 8 remaining fiscal year 1990 appropriations bills.

The year ended with a dramatic Social Security tax cut proposal by Senator Moynihan, chairman of the Senate Finance Subcommittee on Social Security and Family Policy. Senator Moynihan, a long-time critic of the use of Social Security reserves to cover up the true Federal operating deficit, proposed to cut Social Security taxes and place the Social Security trust fund on a pay as you go basis.

Senator Moynihan theorized that his approach was the only way to protect the Social Security trust fund from budgetary abuse. Further, he argued that it was unconscionable to rely on a largely regressive Social Security tax to finance the deficit and the general operations of the Government. Although Congress was not in session when Senator Moynihan offered his proposal, the concept received a great deal of attention. Because proposals to cut taxes always are the recipient of much support, it is likely that Senator Moynihan's initiative will be a priority hearing topics for numerous committees during the second session of the 101st Congress.

A. BACKGROUND

1. The Budget Process

The Federal budget process is a prime example of the American Government's concept of shared powers. The provisions of Article 1 of the Constitution relating to the "power of the purse" gives Congress primary control over financial affairs. However, while the budget is not explicitly mentioned in Article II detailing executive powers, the President's general prerogative to see that the laws are faithfully executed makes the President a major partner in the budget process. From the outset, Congress has had to rely on the discretion of executive branch officials to implement the legislative provisions regarding public expenditures.

The Constitution does not contain specific provisions regarding a budget process. Informal procedures were developed and sufficed for many years until the Budget and Accounting Act of 1921 provided the framework for executive budgeting. This law requires the President to submit a consolidated budget proposal to the Congress each year. The President's budget, which has the status of recommendations, provides the starting point for congressional consideration of upcoming budgetary decisions.

In recent years, Congress has sometimes used the vehicles of a single omnibus continuing resolution to fund the entire Federal Government; this was the case in both fiscal years 1987 and 1988. However, in 1988 there was a return to more traditional budget procedures in the action on measures for fiscal year 1989 with appropriations enacted in 13 separate bills, each of which is in the purview of a subcommittee of the House and Senate Appropriations Committees. Also, according to long-standing congressional procedures, the Appropriations Committtees are supposed to conform to provisions in the authorizing legislation, emerging from the various congressional authorizing committees.

In practice, particiularly in recent Congresses, this procedure has not been closely followed. After the enactment of the regular appropriations for a given fiscal year, it is sometimes necessary to provide additional funding in a supplemental appropriations measure. Further, when appropriations laws are not enacted before the start of the fiscal year on October 1, short-term continuing resolutions often are used to provide temporary funding and allow Government operations to continue uninterrupted.

2. CONGRESSIONAL BUDGET RESOLUTION AND RECONCILIATION LEGISLATION

The budget process underwent substantial change as a result of the Congressional Budget and Impoundment Control Act of 1974. This law sought to restore to Congress some of the fiscal powers which had been surrendered over the years to the President by providing for a more coordinated and systematic congressional decisionmaking approach to the budget. The intent was to improve Congress' ability to view the budget as a whole and also to promote discipline among the authorizing committees.

The 1974 Budget Act established a congressional budget process centered around a concurrent resolution on the budget, scheduled for adoption prior to legislative consideration of revenue, spending, or debt-limit measures. (The law originally provided for adoption of two budget resolutions each year, but was amended in 1985 to provide for a single resolution to be adopted by April 15.) The budget resolution then sets the parameters for subsequent spending and revenue decisions which are made in separate tax bills, appropriations bills, and other measures.

Another component of the congressional budget process provided for in the 1974 law, and in use since 1980, is the reconciliation process. This is a procedure to change existing laws to conform spending and revenues with the decisions in the budget resolution. The submissions from the committees are assembled by the House and Senate Budge Committees into a single reconciliation measure. According to the timetable, the deadline for action by Congress on reconciliation is supposed to be June 15.

3. Recent Developments

The acceptance of special negotiations between the White House and Congress, outside the usual framework of the budget process, constitutes a recent development of note. The first of these sessions, known as the "budget summit," was held in the aftermath of the stock market plunge in October 1987. At that time, President Reagan and congressional leaders apparently recognized the necessity of bipartisan action to calm the financial markets and agreed to a series of meetings. In these negotiations, all elements of the budget, with the exception of Social Security, were on the table.

A compromise summit agreement on deficit reduction measures was reached on November 20, 1987. The summit deal proposed a package consisting of new revenues, user fees, spending cuts, and asset sales, projected to net a total savings of $30.2 billion for fiscal year 88 and $45.9 billion for fiscal year 89. The agreement stipulated limits on new budget authority and outlays for defense, international affairs, and domestic discretionary spending. In December, Congress enacted two laws to implement the agreement—a full-year omnibus continuing resolution in lieu of separate appropriations bills for fiscal year 88 (P.L. 100-202) and an omnibus reconciliation measure (P.L. 100-203), to bring entitlement programs and revenues into line with the requirements of the agreement.

Another round of budget summit negotiations commenced in March 1989. A month later, on April 14, 1989, President Bush and the joint leadership of Congress announced a Bipartisan Budget Agreement for Fiscal Year 1990, designed to meet the Gramm-Rudman-Hollings deficit reduction target of 100 billion for the year. (See further discussion of its provisions, see "Budget Legislation" section, below.)

Other recent developments relating to the budget process can be grouped under the rubric of "budget reform." President Bush has endorsed various reform proposals, many of which were advocated previously by President Reagan, such as enhanced rescission authority and an item veto for the President. Several measures incorporating provisions for budget reform were introduced in 1989, with further action possible in the second session of the 101st Congress. Meanwhile, important changes in the budget process were enacted as a part of the Gramm-Rudman-Hollings legislation in 1985 and 1987, and additional amendments to this law are under consideration.

B. THE GRAMM-RUDMAN-HOLLINGS ACT

In recent years, Congress has become increasingly frustrated with its budget process. Efforts to control the deficit in the context of appropriations bills have caused numerous delays and additional differences complicated the ability to produce conference reports.

Congress has resorted to a series of continuing resolutions to permit agencies and departments to continue to pay salaries and operate programs until their regular appropriations become law. Reconciliation bills have been delayed further and further each year, to where the reconciliation bill for fiscal year 1986 was not passed until April 6, 1986—more than 6 months after the fiscal year started on October 1, 1985.

The Federal deficit has increased at what most consider to be an alarming rate. The total national debt surpassed the $2 trillion mark in 1985. Concerned about the potentially harmful economic effects of spiraling debt and spurred by constituent pressure to control the deficit, Congress searched for measures to enforce discipline in the budget process and limit congressional discretion. Measures proposed have included a constitutional amendment to require Congress to report a balanced budget each year and legislation to provide the President with authority to veto individual line items in appropriations bills.

1. History of the Act

The need to raise the debt ceiling above $2 trillion in the fall of 1985 triggered a response in the Senate. In September, Senators Phil Gramm, Warren Rudman, and Ernest Hollings offered an amendment to the debt ceiling bill to reform the budget process by forcing the Congress to achieve specific deficit reductions targets each year to eliminate the deficit by 1991. Earlier versions of the bill received considerable bipartisan interest from both Houses as well as from the White House. Many Members feared the political and economic consequences of increasing deficit spending, yet were unwilling to set automatic reductions in motion. However, pressures to reduce the deficit were overwhelming and the Balanced Budget Act was signed into Public Law 99-177 in December 1985.

2. Deficit Reduction Targets and Sequestration

Gramm-Rudman-Hollings provides for annual reductions in the budget deficit. To reach the original goal of a balanced budget by fiscal year 1991 (stretched out to fiscal year 1993 by the 1987 amendments), it specifies deficit targets for intervening years. In any year in which deficit targets are exceeded, the excess amount is to be automatically cut from the budget under a process known as sequestration. The act allows for a $10 billion margin-of-error over the deficit target for each year except the last, before sequestration occurs. The 1987 revisions also set maximum sequestrable amounts for fiscal year 1988 and 1989 at $23 billion and $36 billion respectively.

The Gramm-Rudman sequestration process does not list specific cuts for particular programs, but calls for arbitrary, across-the-board reductions in all programs not specially protected. Only when Congress and the President do not pass a budget within the target limit will automatic spending cuts be set in motion. When this occurs, the excess deficit is to be divided in half, one-half of the cuts is taken from the defense budget and the other half from domestic programs. The act sets up a procedure for calculating the resulting cuts in each program. Cuts in each program must come from unobligated funds. Obligated funds cannot be cut because this would put the Government in a position of breaching numerous contracts and commitments.

Gramm-Rudman-Hollings originally provided that a Presidential sequestration order be triggered automatically upon the issuance of a sequestration report (prepared by the Comptroller General of the General Accounting Office) which projected a deficit for a fiscal year in excess of the amount allowed under the act. This procedure was invalidated in 1986 by the Supreme Court, which, in *Bowsher* v. *Synar*, found the procedure to be unconstitutional because it violated the separation-of-powers principle by vesting executive power in a legislative branch officer. However, in anticipation of the possible invalidation of the automatic triggering procedure, Congress included fallback procedures in the act. These provided for the triggering of sequestration dependent upon the enactment into law of a joint resolution setting forth the contents of the joint Office of Management and Budget/Congressional Budget Office sequestration report. The 1987 revision further modified the process by restoring an automatic mechanism for sequestration, triggered by an OMB report.

3. Reductions in Programs Affecting the Elderly

Gramm-Rudman-Hollings controls the funding for Federal programs in two ways. First, the deficit targets encourage Congress to reduce spending by cutting or even restructuring programs. Second, if targets are not met and sequestration is called for, programs affecting senior citizens would be affected, at least partially, by the automatic cuts. Benefits paid under Social Security, Railroad Retirement Tier I, Medicaid, Food Stamps, SSI, and veterans pensions are fully protected from sequestration. However, no such protection is given to the administrative costs of these programs, and there is a danger that the quality of service might deteriorate.

The Federal civil service and military retirement program, Railroad Retirement Tier II, and Black Lung disability, originally were subject to reductions up to the full amount of the annual cost-of-living adjustments (COLAs). In fact, as directed by Gramm-Rudman-Hollings, the 3.1 percent COLAs scheduled to go into effect January 1, 1986, were canceled under a Presidential sequestration order and reaffirmed by Congress after the Supreme Court decision. Subsequent legislation, however, has exempted these programs from further sequestrations.

If deficit targets are not met, most health care programs including Medicare, veterans' health care, and community health centers are subject to cuts in excess of inflation, but not more than 2 percent. When a sequester occurred in fiscal year 1986, these programs were reduced by 1 percent. Although benefits were not directly reduced, payments to health care providers were cut, straining hospital resources. Further abrupt reductions in payment levels could result in reduced quality of care for Medicare and Medicaid beneficiaries.

Other domestic programs on which the elderly depend are vulnerable to unlimited across-the-board reductions based on a uniform percentage of current spending. When exempted and specially treated programs are removed from nondefense spending, approximately one-sixth of total outlays remain and these programs are particularly vulnerable to severe reductions. In fiscal year 1986, for example, programs which provide important services such as housing, low-income energy assistance, older Americans programs, social services, transportation, health research into Alzheimer's and other diseases, block grants, and home weatherization projects were cut by 4.3 percent.

4. LEGISLATION AFFECTING GRAMM-RUDMAN-HOLLINGS IN 1987

At the conclusion of the second session of the 99th Congress in 1986, it was evident that congressional budget reform would be an important issue before the 100th Congress. Despite some notable legislative accomplishments, such as the Tax Reform Act of 1986, Members expressed continued dissatisfaction with the outcome of Federal budget policies and the operation of legislative budgeting procedures.

Much of the criticism focused on the level of the deficit. Although sequestration had been avoided for fiscal year 1987 by the enactment of several deficit reduction measures, some Members predicted that the actual deficit would exceed the target by a wide margin, like in fiscal year 1986, because of unduly optimistic economic assumptions and other factors. Additionally, some Members complained that the two principal deficit reduction measures for fiscal year 1987, the Tax Reform Act and the Omnibus Budget Reconciliation Act of 1986, would make deficit reduction even harder in future years. Reconciliation, they maintained, relied on the use of gimmicks such as postponing payments so that they fall into the next fiscal year, and one-shot savings like selling Federal loan assets. The tax reform law was expected to reduce the fiscal year 1987 deficit by about $11 billion, but add $15 billion or so to the deficits for fiscal years 1988 and 1989.

In 1987, the Congress began debating a measure raising the debt limit with an amendment restoring an automatic sequestration trigger. (This was in response to the 1986 Supreme Court ruling which invalidated the automatic trigger for sequestration.)

Adding fuel to the fire of debate was an OMB/CBO joint sequestration report that projected a fiscal year 1988 deficit of $153 billion—$45 billion above the statutory target. Sequestration implemented according to the terms of this report (without any modification of the deficit target) would have required that outlays be reduced by 12.9 percent for defense programs and 19 percent for nondefense programs. There was widespread agreement that cuts of this magnitude not only would be overly severe, but also could actually harm the economy.

After months of debate about how to fix the Gramm-Rudman-Hollings sequestratin process and modify the deficit targets, Congress in September 1987 enacted changes in the 1985 Balanced Budget Act as part of H.J. Res. 324 extending the permanent statutory limit on the public debt. The two major purposes of these changes were to restore the automatic tigger for sequestration that had been invalidated by the Supreme Court and modify the timetable for achieving a balanced budget in light of persistent high deficits. (See Table 1.)

TABLE 1. ORIGINAL AND REVISED DEFICIT TARGETS IN THE 1985 BALANCED BUDGET ACT AS AMENDED

[Amounts in billions]

	Original target	Revised target
Fiscal year:		
1986	171.9	
1987	144	
1988	108	144
1989	72	136
1990	36	100
1991	0	64
1992		28
1993		0

5. Legislation Affecting Gramm-Rudman-Hollings in 1989

As the 101st Congress began its work, considerable attention in Congress continued to focus on proposals to change the sequestration process under the Gramm-Rudman-Hollings Act. One issue of particular concern involves the treatment of Social Security. Under current procedure, Social Security trust funds are treated as "off-budget"; they are excluded from budget totals for Federal outlays and receipts in the budget documents. However, the 1985 Gramm-Rudman-Hollings law, which mandated the off-budget status, also stipulated that these same Social Security trust funds be included in calculating compliance with the deficit targets as specified in the act. Thus, the off-budget transactions of the Social Security trust funds came to be reported in a special chapter in the Budget Appendix, with the on-budget and off-budget amounts eventually summed to arrive at totals for the Federal Government.

This current arrangement, with Social Security trust funds classified as off-budget and yet still counted in budget estimates used to determine compliance with the yearly deficit targets, has proven troubling to Chairman Pryor, Senator Heinz, and many others within Congress. In recent years, the Social Security trust funds have been in surplus, estimated to be $65 billion in fiscal year 1990. (The surplus is accumulating in anticipation of an unprecedented surge in claims on the funds as the "baby boom" generation ages.) By including the surplus from these trust funds in deficit calculation, the size of the Federal deficit is thereby "reduced," easing the effort at complying with Gramm-Rudman-Hollings targets. But many fear that current accounting procedures disguise the true magnitude of the deficit problem and postpone painful, but necessary, budgetary decisions. There is also concern that the current method may potentially weaken the future solvency of the Social Security system. On the other hand, removing Social Security from deficit calculations would definitely increase the difficulty of complying with existing deficit targets and might require further revision of the targets. Or if the targets were not revised downward, automatic sequestration could bring about such drastic deficit reduction in the short run as to be economically unsound or politically unacceptable.

Several measures to address these concerns were introduced in Congress in 1989. (These proposals, as well as the issues they raise, are outlined in much more detail in the Social Security chapter.) Most proposals, however, seek to remove Social Security from deficit calculations immediately, and concurrently to revise deficit targets and stretch out the timetable for achieving a balanced budget beyond the current deadline of fiscal year 1993.

While no final action was taken on removing the Social Security trust funds out of the deficit reduction calculations, the end of 1989 brought with it numerous hearings and floor debates on this issue. Specifically, committees holding hearings included the Senate Budget Committee and the Senate Governmental Affairs Committee, as well as their House counterparts.

Finally, Senator Moynihan's Social Security tax cut proposal added more attention to this issue. The proposal received an extraordinary amount of attention, but did not immediately gain an abundance of supporters. This was primarily because most realized that a tax cut would almost invariably necessitate a separate and potentially unpopular alternative tax increase. Others concluded it would be best to evaluate whether the proposal, as President Bush charged, would be viewed as an attack on the Social Security system. Regardless of what happens with Senator Moynihan's initiative, it seems likely that it assures that the Congress will pass legislation in 1990 that removes the Social Security trust funds from the deficit calculations of the Gramm-Rudman budget law.

C. BUDGET LEGISLATION

1. Administration's Proposals for Fiscal Year 1990

President Reagan submitted his final budget on January 9, 1989. Using economic assumptions considered overly optimistic by many, the President's budget projected a deficit of $92.5 billion for fiscal year 1990 (under the $100 billion Gramm-Rudman-Hollings deficit target). He proposed an increase in outlays from fiscal year 1989 to fiscal year 1990 of $14.8 billion, but with variations across programs. As stated in his budget message, the budget request "proposes that some programs—such as those for AIDS research and prevention, drug enforcement, and technology development—receive significant funding increases, while others are reduced, reformed, or, in some cases, terminated."

Beyond the Social Security Program and the National Institutes of Health, programs serving the elderly did not fare too well in the Reagan budget proposal. For example, Medicare, Medicaid, Federal housing programs for the elderly, and civil service, military and railroad retirement programs were targeted for significant cuts. Advocates for older Americans became concerned because they feared President Bush's transition budget might largely mirror President Reagan's submission. Such fears found some justification in the February 9, 1989, budget proposal offered by President Bush. The Bush budget, while less severe and specific, appeared very similar to the January budget. Among a number of proposals of concern was his $5 billion plus proposed reduction in the Medicar Program ($2 billion of which would come from unspecified cuts). Also, the projected savings of $1.4 billion from a proposed freeze on civilian, military, and railroad (tier II) retirees' cost-of-living adjustments generated considerable uneasiness.

2. BIPARTISAN BUDGET AGREEMENT AND THE CONGRESSIONAL BUDGET RESOLUTION

The bipartisan budget agreement, announced on April 14, 1989, by the President and the joint leadership of Congress, sought to meet the Gramm-Rudman-Hollings deficit target of $100 billion for fiscal year 1990. CBO and OMB differed in their estimates of savings from components in the agreement, because of their different eceonomic projections and budget baselines, but both CBO and OMB projected a final deficit for fiscal year 1990 of $99.4 billion. The official figures in the agreement were based on the administration's OMB economic projections at the time it was developed. The deficit reduction plan in the agreement, according to these calculations, totalled $23.7 billion, consisting of an $8.5 billion increase in revenues, a $9.5 billion reduction in total spending (although actually providing for a $2.5 billion increase in the nondefense discretionary spending category), and a $5.7 billion sum to be realized from asset sales.

Action on the budget resolution for fiscal year 1990 was delayed for a time as the budget summit negotiations dragged on longer than anticipated. However, once the bipartisan agreement was anouced in mid-April, the budget resolution moved quickly through Congress. By mid-may 1989, it had been reported and passed by both Houses of Congress. As adopted, the budget resolution recommended $1,165.2 billion in outlays, $1,065.5 billion in revenues, and a deficit of $99.7 billion. The budget resolution proposed a reduction in Medicare spending of $2.3 billion, about half of the decrease called for in the President's budget.

3. APPROPRIATION MEASURES

In recent years, the reliance on omnibus legislation, epitomized by the passage in December 1987 of the thousand-plus-page $605 billion appropriations measure for fiscal year 1988, and the even longer reconciliation law, has become a growing concern. President Reagan threatened a veto should still another omnibus appropriations measure follow the next year. But after several years of omnibus full-year continuing resolutions, in the fall of 1988, Congress completed action on all 13 regular appropriation bills before the start of the new fiscal year on October 1. This was the first time since 1976 (fiscal year 1977) that Congress had avoided the need for even a short-term continuing resolution to tide over funding of the Federal Government at the start of a new fiscal year.

In 1989, Congress succeeded in passing all 13 regular appropriation bills before adjourning on November 22. However, three short-term continuing resolutions (CRs) proved necessary—the first expiring October 25, the second through November 15, and the third until November 20. Only one fiscal year 1990 bill was signed before November 1; eight bills were not signed until the closing hours of the session, after the expiration of the third CR. House-Senate disagreements delayed some measures, and then four bills (including two making appropriations for the District of Columbia) were vetoed by the President. Still, by avoiding an omnibus continuing resolution, 1989 could be characterized as the second year in a row that the usual process for appropriation bills prevailed.

4. RECONCILIATION

Reconciliation is an optional process provided for in the Congressional Budget and Impoundment Control Act of 1974, whereby Congress makes any necessary changes in permanent statutes (spending and revenue laws) in order to bring them into conformity with the levels set in the budget resolution. To accomplish this, budget resolutions may contain reconciliation instructions to one or more committees, directing them to recommend changes in existing law or pending legislation within their jurisdictions; the House and Senate Budget Committees then compile the various submissions without modification into a reconciliation bill. In recent years, reconciliation bills have become a major focus for deficit reduction efforts and a principal instrument for implementing provisions of budget agreements between the President and Congress. The must-pass nature of the reconciliation bill also typically attracts a variety of somewhat extraneous provisions.

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) received final House and Senate approval in the last hours of the session, and was signed by the President on December 19, 1989. The new law incorporated various provisions from the April bipartisan budget agreement, as well as complying with the fiscal year 1990 budget resolution, for a deficit reduction package placed at $14.7 billion in savings. (According to CBO, the measure will save $17.75 billion, but lawmakers discounted $300 million in questionable cuts and $2.7 billion from accelerated tax collections.)

A considerable portion of the savings, tagged at $4.55 billion for fiscal year 1990, came from retaining cuts in domestic and defense programs amounting to about one-third (35.6 percent) of those stipulated in the final sequestration order of October 15, 1989; the savings were equivalent to the effect of keeping the original sequestration in place for 130 days. Although conferees succeeded in stripping many so-called extraneous provisions from the bill, the omnibus measure still contained some significant provisions, including a major overhaul of the system for reimbursing physicians under Medicare.

5. SEQUESTRATION

Under the Gramm-Rudman-Hollings procedures, CBO and OMB issue initial sequestration reports in August and final reports in October. If the budget deficit for the coming fiscal year, as projected by OMB in its October report (CBO's report is advisory), exeeds the target plus the $10 billion cushion, then sequestration is implemented.

The initial OMB report projected the fiscal year 1990 baseline deficit at $116.2. While this amount was $16.2 billion above the deficit target, it was only $6.2 billion above the threshold for triggering sequestration (given the $10 billion cushion). OMB thus concluded in the August report that "Full implementation of the Budget Resolution should be sufficient to avoid sequester."

However, the reconciliation package, and most regular appropriations bills, were not in place by mid-October, when OMB issued its final sequestration report, and on October 16, the President issued the final sequestration order for fiscal year 1990. The final OMB report had estimated the deficit at $116.1 billion, so the sequestration order required $16.1 billion in outlay reductions for fiscal year 1990. This necessitated uniform reductions of $8.05 billion each in defense and nondefense spending, and translated into across-the-board cuts of 4.3 percent in defense and 5.3 percent in nondefense programs, according to rules specified in the Gramm-Rudman-Hollings Act. (It is important to keep in mind that an estimated 64 percent of the fiscal year 1990 budget is exempt from sequestration; major exemptions include Social Security, Federal retirement and disability programs, certain low-income programs, and net interest.)

OBRA 1989 provided for preparation of a revised final OMB sequester report for fiscal year 1990, as well as a new Presidential sequester order. Both were issued on December 27, 1989, whereupon the October 16 sequester order was rescinded, as stipulated in OBRA 1989. According to the December sequestration calculations, the revised deficit reduction requirement of $5.734 billion in fiscal year 1990, called for a uniform reduction percentage of 1.5 percent in defense programs and 1.4 percent in nondefense programs. (Because of special rules for crediting appropriations accounts funded below the Gramm-Rudman-Hollings baseline, actual reductions achieved under the revised sequester totalled approximately $4.55 billion.)

D. PROGNOSIS

Following a major and unresolved battle between the congressional leadership and the executive branch over President Bush's capital gains proposal in 1989, it will be extremely difficult to achieve a bipartisan agreement on the fiscal year 1991 budget in 1990. Adding to the already extremely complicated budget debate, Senator Moynihan's proposal to cut Social Security taxes is likely to highlight an increasing reliance on regressive taxes to finance the general operations of the Federal Government.

Debates on the merits of cutting taxes (in an attempt to encourage investment or to restore more fairness), may well overshadow discussions on how best to reduce the deficit. In an election year, it will be far easier to discuss tax cuts than deficit reduction proposals.

It appears quite possible that the two primary and competing tax cut proposals (President Bush's capital gains versus Senator Moynihan's Social Security tax cut) will have the effect of neutralizing one another and, in the end, none will be enacted. However, while there will be much talk about these proposals, it seems likely that most Members of Congress will be as silent as possible when it comes to the need to cut spending or increase taxes to reduce the deficit. Most Members will prefer to debate how we should spend the "peace dividend" that is hoped to result from a reduced Soviet threat. At least for fiscal year 1991, however, it appears that any such dividend will be extremely modest.

On top of the preliminary discussion about how much of a peace dividend was available, disputes on the budget were already starting early in 1990, when President Bush submitted his fiscal year 1991 budget proposal. While Social Security was not targeted for cuts, major budget assaults proposed included those aimed at Medicare, the civil service, military and railroad retirees, and the Low Income Home Energy Assistance Program (LIHEAP). More specifically, the President's budget proposal singled out the Medicare Program, Government retiree programs, and LIHEAP for $5.5 billion, $1.5 billion, and $400 million in cuts, respectively.

Beyond the controversy surrounding large budget cut proposals for some social programs, the President was criticized, once again, for using overly optimistic economic assumptions. In fact, CBO concluded that the President's budget proposal fell $36 billion short of the $64 billion Gramm/Rudman deficit target. If CBO's estimate is correct, there will be even greater pressures to cut programs serving older Americans, particularly if the Congress and the administration opt not to look at revenue raising options.

At this writing, it appears unlikely that there will be a bipartisan budget agreement. Should no agreement be achieved, the Gramm-Rudman budget-cutting measure looms in the background ready to make its across-the-board cuts. Since Gramm-Rudman recission and sequestor cuts will hurt the domestic programs much more than defense programs, it appears that the Bush Administration may have a trump card it can play if it is not satisfied with the budget produced by the Congress.

Fully realizing the advantage President Bush appears to hold following the unexpected and dramatic changes around the world, and the reduced pressure to continue an arms build-up, the Congress may well discuss modifying the Gramm-Rudman law to reflect these changes. The prospect of permitting a Gramm-Rudman cut to take place raises great concerns in both the Congress and in the aging advocate community. With these and other unknown variables in mind, advocates of older Americans will continue to closely monitor budget activity on programs affecting the elderly during 1990.

Supplement 1

1989 HEARINGS HELD BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

Joint U.S. Senate Special Committee on Aging, U.S. House OF Representatives Select Committee on Aging, Subcommittee on Health and Long-Term Care and Subcommittee on Housing and Consumer Affairs Hearing - Board and Care: A Failure in Public Policy, Washington, D.C., March 9, Hon. David Pryor, Chairman, Hon. Claude Pepper, Chairman, and Hon. James J. Florio, Chairman, Presiding.

Witnesses

Representative Claude Pepper, Chairman, U.S. House of Representatives Select Committee on Aging, Subcommittee on Health and Long-Term Care
David Lazarus, Director of Litigation, Community Health Law Project, East Orange, NJ
Alice Lippold, resident, board and care home, Washington, DC
John Sharp, resident, board and care home, Sacramento, CA
Julie Oetting, long-term care ombudsman, Jefferson County, AL
Ima Ring, sister of board and care resident, Indianapolis, IN
Anne Hart, long-term care ombudsman, Washington, DC
Melva Colegrove, investigator/consultant, Ohio Department of Health, Columbus, OH
Pam Hinckley, owner/operator, board and care home, Cleveland, OH
Mary Beth Africa, long-term care ombudsman, Altoona, PA
Patricia H. Murphy, Director, New York City Long-Term Care Ombudsprogram, New York, NY
Michael Coonan, long-term care ombudsman, Sacramento, CA
Janet L. Shikles, Director, National and Public Health Issues, Human Resources Division, General Accounting Office; accompanied by Alfred Schnupp, Assignment Manager and Chris Rice, Evaluator-in-Charge

Issues Raised and Testimony Summary

This joint hearing was convened to examine the problems within the board and care system. Board and care facilities are an often overlooked, but potentially vital part of the long-term care system in the United States. Because they offer independence and autonomy as well as some supervision, board and care homes can provide some elderly persons with an alternative to more costly institutional care. Unfortunately, according to the GAO report released at the hearing ("Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met," No. GAO/HRD 89-50), far too many homes are providing grossly substandard care that endangers the health and well-being of their residents.

The hearing focused on the reasons for the problems with the board and care system, among them: A lack of State and Federal involvement in oversight and regulation, inadequate training and education for care providers, and levels of funding often too low to provide quality care. While many of the witnesses affirmed these problems, Pam Hinckley, operator of a board and care home, was able to shed some positive light on the issue; namely that board and care is a crucial part of the continuum of long-term care when it is provided in a safe and efficient manner. The hearing illustrated that greater federal and state oversight and regulation of board and care homes are needed.

SSA's Toll-Free Telephone System: Service or Disservice?
Washington, D.C., April 10, 1989, Hon. David Pryor, Chairman, Presiding

Witnesses

Katheryn Lippert, Pittsburgh, PA
Myra Baillie, San Francisco, CA
Judith Price, Akron, OH
Dorcas R. Hardy, Commissioner, Social Security Administration, accompanied by John P. McHale, Project Coordinator, National 800 Number; James Kissko, Senior Executive Officer; and Ruth Pierce, Associate Deputy Commissioner for Operations
Joseph F. Delfico, Director, Income Security Issues, General Accounting Office, accompanied by Thomas Smith, Assignment Manager
William Bechill, Vice Chair, Save Our Security Coalition, accompanied by Roberta Feinstein Havel, Executive Director
John N. Sturdivant, President, American Federation of Government Employees; accompanied by Chapin E. Wilson, Jr., Legislative Representative

Issues Raised and Testimony Summary

The Social Security Administration launched a toll-free teleservice system throughout 60 percent of the country in October 1988. Although the new system is designed to provide answers to questions concerning Social Security and the Supplemental Security Income programs, callers frequently experience busy signals and misinformation. Related concerns include cutting off telephone contact between the public and Social Security field offices and draining staff from field offices to boost staffing at teleservice centers.

SSA Commissioner Dorcas Hardy testified that the toll-free number was highly popular among the public and that agency studies showed very low error rates. According to Joseph Delfico of GAO, however, the studies did not employ sound methodological principles and were therefore inconclusive. He recommended that expansion of the toll-free system not proceed until the busy signal rates were brought under control, and only then, on an incremental basis.

The hearing also exposed SSA's practice of verifying the Social Security numbers (SSN's) of individuals for private companies such as credit bureaus and banks. At the time of the hearing, SSA was preparing a computer run to verify the SSN's of 140 million individuals for TRW, a private corporation. The Chairman strongly criticized this practice, stating that it was possibly the largest breach of confidentiality in the history of the program. A week after the hearing, Commissioner Hardy announced the practice would be halted.

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Intergenerational Educational Partnerships: A Lifetime of Talent To Share, Boca Raton, FL, April 24, 1989, Hon. Bob Graham, Presiding

Witnesses

Daniel Merenda, executive director, National Association of Partners in Education, Alexandria, VA
Laurey Stryker, assistant commissioner of education, State of Florida
James Daniels, deputy superintendent of schools, Palm Beach County, FL
William G. Amey, volunteer from Broward County and retired engineer from Bechtel Corp.; accompanied by Alok Shah, Ely Magnet School, Pompano Beach, FL
Raymond J. Judd, teacher, Escambia County, FL
Bea Fichman, school volunteer, formerly an administrator and now president, Volunteer Braille Services, Inc., Lantana, FL; accompanied by Amy Billman, student, Santaluces High School, West Palm Beach, FL
Maryon Freifelder, volunteer, Miami Beach, FL; accompanied by Terrance Page, student, Miami Central Senior High School, Miami, FL
Carl H. Rowe, volunteer, Safety Harbor FL, accompanied by Robert DeJonge, student, East Lake High School, Tarpon Springs, FL
Lac Vo, junior, Lake Howell High School, Lake Howell, FL
Elvena Holland, volunteer, Ft. Myers, Lee County, FL

Issues Raised and Testimony Summary

This hearing was called by Senator Graham to introduce the success that the intergenerational programs have had in the State of Florida. More than 14,000 older Floridians volunteer every week in Florida public schools. Retirees bring knowledge and experience into the classrooms as substitute teachers, academic tutors, and senior mentors with creative students who have special abilities and talents. With an average of 1 volunteer for every 12 students in Florida public schools, students are receiving a more individualized education. The intergenerational programs are positive for older adults as well; those who have led busy and productive lives need to continue to feel that they are needed and can contribute to society.

The example Florida has set with its intergenerational program should be an example for all States. To help achieve this objective, Senator Graham introduced S. 382, the Business and Citizen School Volunteers of America Act. This bill would provide State education departments throughout the country with a small amount of money to provide training and management help to local school districts.

Federal Implementation of OBRA 1987 Nursing Home Reform Provisions, Washington, D.C., May 18, 1989, Hon. David Pryor, Chairman, Presiding

Witnesses

Janet Tulloch, nursing home resident and author of "A Home is not a Home"; accompanied by Toby Edelman, National Senior Citizens Law Center
Susan Rourke, President, National Citizens Coalition for Nursing Home Reform and Executive Director, Citizens for Better Nursing Home Care
Bruce Spitz, Director of Special Projects, American Red Cross
Linda Rhodes, Secretary, Pennsylvania Department of Aging
Dana Petrowsky, representative of Association of Health Facility Licensure and Certification Directors, and Administrator, Division of Health Facilities, Iowa Department of Health
Kenny Whitlock, Deputy Director, Division of Economic and Medical Services, Arkansas Department of Human Services
Dr. C. Ross Anthony, Associate Administrator for Program Development, Health Care Financing Administration, Department of Health and Human Services; accompanied by Tom Hoyer
Mary Ousley, Administrator, Kenwood House, Richmond, KY
Catherine Price, Executive Director, Church of Christ Homes, Annville, PA

Issues Raised and Testimony Summary

The passage of OBRA 1987 (Public Law 100-203) represents the most significant nursing home reform since Medicare and Medicaid first began to cover nursing home care. Yet, State officials, advocates for nursing home residents, and nursing home providers have serious concerns about the role the Federal Government is playing in the law's implementation. As of March 1989, DHHS had not met any of the 10 deadlines set for 1988 by OBRA.

Because OBRA 1987 requires States to implement the law whether or not they receive guidance from the Federal Government, DHHS' failure to meet these deadlines translates into a great deal of confusion and uncertainty among those who must put the law into practice. For example, OBRA 1987 requires States to begin implementing preadmission screening and annual resident review (PASARR) January 1, 1989, despite the fact that DHHS has not developed any binding rules or regulations as to how they were to proceed. Other concerns brought out during the hearing were concentrated in the areas of nurse aide training, enforcement procedures and increased costs as a result of the new law.

DHHS has devoted considerable time and resources to implementing a new set of rules and procedures 14 months before the deadline set by Congress. In so doing, critical guidance to States and providers on other provisions of the legislation that were to be implemented from late 1988 until the present time has been sacrificed. According to Dana Petrowsky of AHFLCD, the implementation of the new requirements for nursing homes 14 months early is ill-advised and premature. Legislation as important as OBRA 1987 needs thoughtful direction if the high quality of health care for the Nation's elderly and disabled is to ever be realized.

SSA's Representative Payee Program: Safeguarding Beneficiaries From Abuse, Washington, D.C., June 6, 1989, Hon. David Pryor, Chairman, Presiding

Witnesses

Elizabeth Freeland, Sacramento, CA
Mary Miller, Marvell, AR
Audrey Madyun, Paralegal, East Arkansas Legal Services, Helena, AR
Louis D. Enoff, Deputy Commissioner for Programs, Social Security Administration
Michael A. Teefy, AFGE, SSA Claims Representative, Vancouver, WA
Betty Broadhead, AFGE, SSA Claims Representative, Goldsboro, NC
Kim P. Gaines, AFGE, SSA Claims Representative, San Francisco, CA
Curtis L. Child, Attorney at Law, Legal Services of Northern California
Linda J. Olson, Attorney at Law, Legal Aid Society of Metropolitan Denver, Inc.

Issues Raised and Testimony Summary

The SSA's representative payee program authorizes an individual, known as a representative payee, to handle the Social Security or Supplemental Security Income checks for a beneficiary who is too disabled, or otherwise unable to manage his or her own finances. The absence of effective monitoring of payees leaves such beneficiaries vulnerable to financial abuse.

This hearing focused on the careless process in which representative payees are appointed and left unsupervised. Contrary to a 1984 Federal district court ruling that mandated monitoring, SSA does little to screen or monitor payees. A number of witnesses testified to the pervasiveness of abuse among beneficiaries with payees, resulting from the lack of program safeguards.

To improve the payee program, Louis Enoff of SSA cited an agency plan to develop a comprehensive data system to help evaluate and improve the selection process of payees. In response to the problem, Senator Pryor introduced the Representative Payee Abuse Act of 1989. The Act would require the screening and investigation of representative payees, establish safeguards to protect beneficiaries, and develop procedures for monitoring, accounting, and recordkeeping of payees.

Prescription Drug Prices: Are We Getting Our Money's Worth? Washington, DC, July 18, 1989, Hon. David Pryor, Chairman, Presiding

Witnesses

Dennis Styrsky, chief of pharmaceutical products division, marketing center, Department of Veterans Affairs, Hines, IL
Winston Barton, cabinet secretary, Kansas Department of Social and Rehabilitation Services; accompanied by John Alquest, commissioner, Kansas Medical Program
William Mincy, partner, The Lenco Group, Tallahassee, FL
Gerald Mossinghoff, president, Pharmaceutical Manufacturers Association, Washington, DC
Joseph Thomas III, Ph.D., Purdue University School of Pharmacy, West Lafayette, IN
Bruce Laughrey, R.Ph., president, Medi-Span, Inc., Indianapolis, IN
Louis B. Hays, Acting Administrator, Health Care Financing Administration, Department of Health and Human Services
George B. Rathman, chairman of the board, Amgen Inc., Thousand Oaks, CA

Issues Raised and Testimony Summary

This is the first in a series of hearings held to explore the status of the prescription drug industry. Currently it is characterized by rapidly rising costs and the development of relatively few innovative and important new drugs. Between 1981 and 1988, 348 new drugs were brought to the market by the top 25 drug companies; the FDA classified 84 percent of these new drugs and 60 percent of new molecular entities as making little or no contribution to existing therapies.

The drug companies cite the cost of research and development (R&D) as the reason for the rising cost of prescription drugs. The prescription drug inflation rate of 88 percent dwarfed the general inflation rate of 28 percent for the years 1981 through 1988. Yet, as referred to above, only 12 important new drugs were introduced into the market during that time. Citizens are charged higher drug prices to cover the R&D costs of duplicative drugs.

The hearing also focused on the variation in drug prices paid by Medicare, Medicaid, hospitals, the Veterans Administration (VA), and the general public. The VA, an agency of the Federal Government, is able to obtain prescription drugs at prices 40-60 percent less than the prices paid by Medicaid, because the VA negotiates prices with drug manufacturers. The misutilization and inappropriate prescription of drugs play a role in the expanding costs of drugs as well. Because Medicaid programs do not negotiate drug prices, manufacturers are free are free to to raise their prices even when generic competition appears in the market. Moreover, the Government is forced to cut back on pharmacists' payments to recoup losses from rising drug costs.

Access to Care for the Elderly, Aberdeen, SD, August 7, 1989, Hon. Larry Pressler, Presiding

Witnesses

Dr. Richard D. Mulder, M.D., Ivanhoe, MN
Dr. Stephen Schroeder, Miller, SD
Gerald Huss, hospital administrator, Faulk County Memorial Hospital, Faulkton, SD
Ray Hopponen, pharmacist
Wayne Muth, vice president of long-term care, Presentation Health System
Gail Ferris, director, State Program in Adult Services and Aging
Lucille Stafford, Ipswitch, SD
Peg Lamont, former State legislator, Aberdeen, SD

Issues Raised and Testimony Summary

Senator Pressler called this field hearing to address the enormous health care issues in the State of South Dakota and across the Nation, especially in the rural communities. A growing number of the population is uninsured, which results in higher health care costs to cover this uncompensated care. Medicare reimbursement is significantly lower for rural physicians and hospitals, which gives little incentive to pursue a medical career in a rural area. This has led to the closing of more than 800 hospitals in the last 9 years. All of these factors have resulted in inadequate access to care for the elderly.

Physicians and hospital administrators from South Dakota testified to the many problems they face as health care providers. A primary concern is the closing of hospitals. Gerald Huss, a hospital administrator with Faulk County Memorial Hospital, sees some hospitals as having no choice but to close their doors. Yet, he continues, there should be an orderly and well-planned transition to an alternative that would ensure community access to primary care. Currently, this does not occur and the only health care available may be as far as 30 miles away. Access to health services is of primary concern and must be addressed through legislative response.

Joint Special Committee on Aging and The Pepper Commission Hearing - Long-Term Care in Rural America: A Family and Health Policy Challenge, Little Rock, AR, August 22, 1989, Hon. David Pryor, Chairman, Presiding

Witnesses

Mary Anita Andrews, nursing home resident, Little Rock, AR
Velma Gilbert, caregiver of her elderly mother, Pine Bluff, AR
Debra Nelson, caregiver of her chronically ill child, North Little Rock, AR
Edrell Trickle, caregiver of her husband, a nursing home resident, Blytheville, AR
Dr. Joyce Berry, Acting Commissioner, Administration on Aging, U.S. Department of Health and Human Services, Washington, DC
Representative Bill Foster, chairman, House Committee on Aging, State of Arkansas Legislature
Senator Mike Kinard, member, Arkansas Senate Aging and Legislative Affairs Committee, Magnolia, AR
Dr. James Maupin, Arkansas State Board of Health
Herb Sanderson, deputy director, Arkansas Department of Human Services, Division of Aging and Adult Services
Dr. Rosalie Kane, professor of social work and public health, University of Minnesota
Dr. Roger Busfield, president, Arkansas Hospital Association, Little Rock, AR
Benno Salewski, executive director, Arkansas Health Care Association, Little Rock, AR
Amber Reed, president-elect, Arkansas Association of Home Health Agencies, West Memphis, AR
Ernie Yeager, member, Arkansas Pharmacists Association, Jasper, AR
DeMaris Marsh, State director, American Association of Retired Persons, Monticello, AR
Floyd Sexton, member, Arkansas Seniors Organized for Progress, Texarkana, AR

Issues Raised and Testimony Summary

This joint hearing was held to ensure that members of both the Pepper Commission and the Aging Committee would have access to information concerning the special rural population's needs for long-term care and the problems encountered in attaining that care. Currently, 9.3 million Americans are chronically ill and in need of long-term care services. With more than 82 percent residing in the community, the majority of long-term care needs are met through informal sources such as family members. The high cost of prescription drugs and medical treatments puts a tremendous burden on the caregivers. Yet they are not reimbursed for the care they provide. In order to receive reimbursement, the chronically ill patients have to be institutionalized, something most families fear for their relatives and try to avoid at all costs.

Rural America is particularly affected due to the fact that while the elderly comprise 12 percent of the total of the U.S. population, they account for more than 25 percent of the rural population. Also, the rural elderly are twice as likely to be poor than their urban counterparts. Diminishing numbers of health personnel and inadequate transportation further exacerbate the problem.

In the past, long-term care has been talked about in terms of institutional settings. With the number of chronically ill people residing in their homes though, long-term care services need to target home care services, both medical and supportive services as well. The services currently available for long-term care are fragmented and target the very poor. A policy to draw together resources to provide a comprehensive care system is in great demand, and it must be available to all of the chronically ill, not just the very poor who qualify for Medicaid.

Joint Senate Special and House Select Committee on Aging Hearing - Health Care for the Rural Elderly: Innovative Approaches To Providing Community Services and Care, Bangor, ME, September 18, 1989, Hon. William S. Cohen and Hon. Olympia J. Snowe, Presiding

Witnesses

Dr. Gregory O'Keefe, Vinalhaven, ME
Dr. Roger Pelli, Aroostook Valley Health Center, Inc., Ashland, ME
Vera Johnson, Vinalhaven, ME
Roy Gallagher, East Machias, ME
Clarence "Ted" LaLiberty, Jr., board member, Maine Hospital Association; CEO, Miles Memorial Hospital; chairman-elect, American Hospital Association's section on small and rural hospitals, Damariscotta, ME
Craig Bean, CEO, Houlton Regional Hospital, Houlton, ME
Paul Chute, senior vice president, Stephens Memorial Hospital, Norway, ME
Ann Morrison, CEO, Sebasticook Valley Hospital, Pittsfield, ME
Nona Boyink, past president, National Rural Health Association; president, Maine Ambulatory Care Coalition; president, Kennebec Valley Regional Health Agency, Waterville, ME
Christine Gianopoulos, director, Bureau of Elder and Adult Services, Maine Department of Human Services
Ruth Lane, vice chair, Rural Health Centers of Maine, Inc., Augusta, ME
Hilton Power, Ed.D., vice chair, Maine Committee on Aging, Augusta, ME
Brian Rines, Maine Citizens for Quality Health Care

Issues Raised and Testimony Summary

Senator Cohen held this hearing to discuss the problems facing rural elderly patients and the health care providers that serve them. It also focused on the innovative steps that are being taken to adapt the current health care system for meeting the medical needs of these elderly in rural and remote areas. The inadequate rural health care conditions affect the entire population. Yet, the elderly represent nearly 25 percent of the rural population, and they are often in much greater need of health care services. On average, individuals 65 and older are admitted to the hospital twice as often and stay twice as long as younger individuals.

One of the most critical problems facing the rural elderly is the scarcity of doctors and other health professionals. In the past year and a half, two rural hospitals have closed in Maine. In 1988, a total of $4.2 million was lost by Maine's 20 rural hospitals. With the continued threat of hospital closings, Maine has turned to rural health centers to meet the primary health care needs of many rural elderly. In spite of the importance of these health centers to providing access to health care services, their ability to do more to meet the needs of the rural elderly is strained by limits on their grants from the Public Health Service and by the level of Medicare and Medicaid reimbursement. Underfunding also results from the urban/rural differential. Uncompensated care has also added to Maine's current health care problems; uncompensated care resulted in a $40 million shortfall in 1988.

Suggestions for an improved health care system include the expansion of rural transition grants, the provision of funds to help educate health care professionals and to provide incentives for health care providers to go to rural areas, and the guarantee that hospitals will receive their full markup in the Medicare update. There is a need for all of those responsible for serving the elderly to work together to make sure that all senior citizens have access to affordable, quality health care.

Joint Senate Special Committee on Aging and Labor and Human Resources Subcommittee on Labor Hearing - The Older Workers Benefit Protection Act, S. 1511, and The Age Discrimination in Employment Act Amendments of 1989, S.1293, Washington, DC, September 27, 1989, Hon. David Pryor, Chairman, and Hon. Howard Metzenbaum, Chairman, Presiding

Witnesses

Carolyn Betts, Washington, DC
Harry Sousa, Bristol, RI
R. Gaull Silberman, Vice Chairperson, Equal Employment Opportunity Commission, Washington, DC
Charles Shanor, General Counsel, Equal Employment Opportunity Commission, Washington, DC
Horace B. Deets, executive director, American Association of Retired Persons, Washington, DC
Burton D. Fretz, executive director, National Senior Citizens Law Center, Washington, DC
Chris Mackaronis, Bell, Boyd & Lloyd, Washington, DC
Kevin McCarthy, vice president, UNUM Life Insurance Company, Portland, ME
Mark Dichter, Morgan, Lewis & Bockius, Philadelphia, PA
Fred Rumak, Association of Private Pension and Welfare Plans, Washington, DC
James D. Short, ERISA Industry Committee, Washington, DC
Douglas S. McDowell, McGuiness & Williams, Washington, DC

Issues Raised and Testimony Summary

The purpose of this hearing was to examine a ruling of the U.S. Supreme Court in Public Employees Retirement System of Ohio v. Betts, 109 S.Ct. 2854 (1989), that the Age Discrimination in Employment Act does not protect workers from age based discrimination in the area of employee benefits, and to discuss current legislation aimed at overturning the Court's decision.

Carolyn Betts, daughter of the plaintiff in the Betts case, and Harry Sousa, a victim of age discrimination in the area of severance pay, illustrated the tragedy that can result if employers are allowed to discriminate at will in the area of employee benefits. Ms. Betts testified that her mother is now destitute in a nursing home due to the fact that she was denied disability retirement because of her age.

Ms. Silberman and Mr. Shanor testified on behalf of the Equal Employment Opportunity Commission regarding S. 1511 and S. 1293. Both made very favorable comments about the bills and emphasized the importance to older workers of correcting the Betts decision. Mr. Shanor illustrated the need for timely action on this issue by pointing out that the Commission currently has about 30 employee benefit discrimination cases pending which could be dismissed very soon as a result of the Supreme Court's ruling. The remaining witnesses participated in a panel discussion on the technical aspects of both bills.

Medicare Coverage of Catastrophic Health Care Costs: What Do Seniors Need, What Do Seniors Want? Las Vegas, NV, October 10, 1989, Hon. Harry Reid, Presiding

Witnesses

Hon. Bob Miller, Governor, State of Nevada
Margaret Brock, presented by Mel Kalagian, senior services liaison, Office of the Mayor
Roy Fehler, columnist, Las Vegas Review Journal
Daniel Hawley, president, Seniors Coalition Against The Catastrophic Act; accompanied by Mrs. Daniel Hawley
Carla Sloan, director, Cannon Senior Citizens Center, president, Aging Services Directors Organization
Jack Fields, attorney, City of Las Vegas Senior Citizens Law Project
Anne Koepsell, administrator, Kimberly Quality Care, Las Vegas, NV
Mary Jo Greenlee, administrator, Hollyhock Adult Day Care Center, Adult Day Care Division, Clark County Economic Opportunity Board.
Bertha Warwick, social service officer, Clark County, NV

Issues Raised and Testimony Summary

Senator Reid held this hearing to focus on the needed reform of the health care funding formula in the Catastrophic Act. The total burden of this expensive program has been placed on those with fixed incomes, and according to Senator Reid, this is unjust. Catastrophic illness can destroy not only the lives of the victims, but the lives of their families as well. Governor Bob Miller testified that the efforts of Catastrophic should not be completely repealed; it is essential that the U.S. Congress continue to work with the issue due to its importance to the elderly population.

Witnesses emphasized three goals of long-term care benefits: Allowing the elderly to maintain their independence as long as possible; supporting the family members who are providing care for those who are no longer independent; and utilizing the scarce health care dollars as efficiently as possible.

Joint Senate Special Committee on Aging and The Pepper Commission Hearing - The Shadow Caregivers: American Families and Long-Term Care, Philadelphia, PA, November 13, 1989, Hon. John Heinz, Presiding

Witnesses

Jack Armstrong, Wyncote, PA
Joyce Singer, York, PA
Stewart and Terry Idelson, Philadelphia, PA
Miriam Burnett, Philadelphia, PA
Christina Rodgers, Hershey, PA
Linda Rhodes, secretary, Pennsylvania Department of Aging, Harrisburg, PA
Maggie Kuhn, founder and national convener, Gray Panthers, Philadelphia, PA
Mary Kay Pera, executive director, Pennsylvania Association of Home Care Agencies and Coordinator, Pennsylvania Long-Term Care Campaign, Harrisburg, PA
Adele Hebb, president, Community Home Health Services, Philadelphia, PA
Dan English, president, Action Alliance, Philadephia, PA
Charles Daly, vice president, Delaware Valley Hospital Council, Philadelphia, PA
James A. Dorsch, Washington counsel, Health Insurance Association of America
Dr. Sheldon Jacobson, M.D., emergency department medical director, Hospital of the University of Pennsylvania, Philadelphia, PA

Issues Raised and Testimony Summary

This joint hearing convened to analyze the problems facing the millions of shadow caregivers in the United States. These shadow caregivers are those who out of love and loyalty turn their lives on end for a chronically ill family member. Sustaining the level of care required emotionally cripples some families and financially destroys others. At a minimum, families find themselves shut off from jobs, friends, and community.

Many of these families are part of another critical statistic: The 37 million Americans with no health coverage. America is among the wealthiest nations in the world, with one of the most technologically advanced medical communities. Yet current policies often force a choice between food and housing or preventive medical care for the uninsured; and institutionalization or piecemeal services and personal sacrifice for caregivers of the chronically ill. Of the 80-plus Federal programs directed toward assisting individuals with long-term care problems, for example, most operate under a constricting framework of benefits that only partially disguises how far the gaps outnumber the options in coverage.

Our Nation's Elderly: Hidden Victims of the Drug War?
Washington, DC, November 15, 1989, Hon. David Pryor, Chairman, Presiding

Witnesses

Elizabeth Holtzman, District Attorney of Brooklyn, NY, and City Comptroller-Elect, New York City, NY
The Honorable Mitch McConnell, U.S. Senator from the Commonwealth of Kentucky
Evelyn A. Blackwell, Washington, DC
Elsie Taylor-Jordan, Alexandria, VA
Rosemary Dalton, Miami, FL
Eric Straughter, President, Straughter Associates, Boston, MA
Robert Crawford, Sergeant, Oakland Police Department, Oakland, CA
Robert Smith, Deputy Director for Planning and Development, Central Arkansas Area Agency on Aging
Robin Mayrl, Director of the Milwaukee County Office on Aging, Milwaukee, WI
Clarence "Bud" Albright, Deputy General Counsel, Department of Housing and Urban Development

Issues Raised and Testimony Summary

This hearing highlighted the impact of the drug crisis on the elderly population. Although the drug crisis affects the entire population, the vulnerability of the elderly makes them even greater targets of crime and abuse. Witnesses provided testimony on the increasing problems the elderly are forced to face in light of the Nation's drug crisis.

Drug-addicted or drug-dealing children or grandchildren have in some cases taken over an elderly relative's home. The elderly see family members using their Social Security and pension checks, or carefully tended savings accounts to buy drugs. The number of abused elderly cases has increased dramatically. District Attorney Elizabeth Holtzman of Brooklyn testified to a 400 percent increase in elder abuse cases, much of which she attributes to drug-addicted family members.

The decrease in Federal support of housing and supportive services has furthered the vulnerability of the frail elderly through their increasing isolation in dangerous crack-infested neighborhoods. Social workers and home healthcare providers are often reluctant to go into known drug areas, thus causing some of the older residents of those neighborhoods to go without needed services. A rising number of grandparents are raising grandchildren abandoned or abused by their drug-addicted parents, which can result in great financial and emotional stress. These are just a few of the many situations the elderly face as the drug crisis escalates. This hearing sought to highlight the enormous problems many elderly encounter because of the drug crisis and to ensure that these often hidden victims of drug abuse are not forgotten.

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Skyrocketing Prescription Drug Prices: Turning a Bad Deal Into a Fair Deal, November 16, 1989, Washington, DC, Hon. David Pryor, Chairman, Presiding

Witnesses

Jake Green, Winchester, KY
Leona Bivens, Seal Beach, CA
Derek Hodel, executive director, People With AIDS Health Group, New York, NY
R. Michael Berryman, chairman of the board, Commonwealth of Virginia Medical Assistance Services, South Hill, VA
Tery Baskin, director, chairman, Pace Alliance, Little Rock, AR
Norrie Wilkins, vice president of pharmaceutical management, Partners National Health Plans; accompanied by Donna Schmidt, manager for clinical pharmacy programs, Partners National Health Plans, Minneapolis, MN
Guido Adriaenssens, Belgian Consumer Association, Brussels, Belgium
Guido Sermeus, Belgian Consumer Association, Brussels, Belgium

Issues Raised and Testimony Summary

This is the second in a series of hearings held to examine the prescription drug crisis. While the first hearing, held July 18, provided an overview of the problems resulting from the increasing cost of prescription drugs, the focus of this hearing was to address ways in which these high costs could be brought down to a reasonable level. The escalation of prescription drug costs is just beginning. Since 1984, drug costs have been the third fastest rising cost in Medicaid, now accounting for $33 billion/year in spending, which is more than Medicaid reimbursements to physicians. Several witnesses offered their strategies for drug pricing reductions as potential models for national implementation through Medicaid. Witnesses described ways the Government could negotiate prices, and then receive rebates from manufacturers, whithout reducing payments to community pharmacists.

The testimony of Guido Adriaenssens of the Belgium Consumer Association provided a comparison of drugs commonly used in both the United States and Europe. The U.S. prices were as much as 15 times higher for some commonly prescribed drugs. The high costs in the United States are coupled with a high consumption rate as well. Guido Sermeus, also of the Belgium Consumer Association addressed different methods which are used to control drug costs in Europe. Many Americans are turning to Europe as a potential relief source from the exorbitant U.S. prices of prescription drugs. Yet, importing drugs is a difficult process being complicated more as U.S. drug manufacturers request bans on such imports.

Clearly, the rising cost of prescription drugs can not continue at its current rate. In a free market system, the producer and consumer negotiate for fair prices, but all too often, certain drugs are available through a single manufacturer. This creates high costs for the local pharmacies and consumers. Measures for cost and consumption reduction of prescription drugs need to be implemented and enforced through legislative action.

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Untie the Elderly: Quality Care Without Restraints, (symposium with Kendal Corp.) Washington, DC, December 4, 1989.

Witnesses

Lloyd Lewis, Executive Director, The Kendal Corporation, Kennett Square, PA
Keith Grant, husband of nursing home patient
Susan McTyier, daughter of nursing home patient
Jill Blakeslee, Director for Health Services, The Kendal Corporation, Kennett Square, PA
Mildred Simmons, Assistant Director of the Office of Health Care and Prevention, Colorado Department of Health, and president, Association of Health Facility Licensure and Certification Directors
Joanne Rader, Director of the Mental Health Department, Benedictine Nursing Center, Mount Angel, Oregon
Fred Watson, Executive Director, Christian City Convalescent Center, Atlanta, GA
Arnold Silverman, President, Skil-Care Corporation, Yonkers, NY
David Mettler, director of risk management, Hillhaven Corporation, Tacoma, WA
Alan Reeve Hunt, Esq., Montgomery, McCracken, Walker and Rhoads, Philadelphia, PA
Marshall B. Kapp, J.D., M.P.H., Professor, Department of Community Health, Wright State University, Dayton, OH
Kurt Torell, Director for Education and Organizational Development, The Kendal Corporation, Kennett Square, PA
Beryl Goldman, Associate Director for Health Services, The Kendal Corporation, Kennett Square, PA
Henrietta Roberts, Executive Director, Stapely in Germantown, Philadelphia, PA
Lynne Mitchell-Pedersen, R.N., clinical nurse specialist, St. Boniface General Hospital, Winnipeg, Manitoba, Canada
Carter Catlett Williams, social work consultant in aging, Bethesda, MD
Sarah Burger, National Citizens Coalition for Nursing Home Reform, Washington, DC
Alan Friedlob, nursing home branch chief, Health Care Financing Administration
Connie Cheren, R.N., director, Office of Licensure and Certification, State of Florida, Tallahassee, FL
T. Franklin Williams, M.D., Director, National Institute on Aging
Anne Morris, gerontology program manager, American Occupational Therapy Association, Bethesda, MD
Greg Pawlson, M.D., M.P.H., professor and acting chairman, Department of Health Care Sciences, George Washington University Medical Center, Washington, D.C.
Dermot Frengley, M.D., associate professor, Division of Restorative and Geriatric Medicine, Case Western Reserve University, Cleveland, OH
Lois Evans, University of Pennsylvania School of Nursing, Philadelphia, PA

Nancy Dubler, LL.B., associate professor, Department of Social Medicine, Albert Einstein College of Medicine, Bronx, NY

Issues Raised and Testimony Summary

This symposium was developed through the combined efforts of the Senate Special Committee on Aging and the Kendal Corporation, a not-for-profit organization which operates long-term care facilities for the elderly. The Kendal Corporation developed a program entitled "Untie the Elderly," which is designed to increase public awareness of the damaging effects of restraints and to offer support and guidance to facilities interested in facilitating restraint-free care. Traditionally, institutional long-term care practice has included the use of restraints. Yet, standards and practice change over time, and this symposium sought to initiate the change toward care in a restraint-free atmosphere.

Testimony by a number of health professionals focused on the need for proper restraint care, believing that restraints are necessary for a limited number of patients. Restraints should only be used if there is a threat of the patient harming himself/herself or another patient in the facility. The restrained patients must be carefully monitored in order to assure that the restraints are removed at the earliest possible time. Physicians, nurses, the patients and their families need to be involved with health care assessment and management, which includes alternatives to the use of restraints.

All too often, restraints are used to compensate for inadequate staffing or to prevent patients from falling. The former is an obvious abuse of restraint use. The latter has been proven false; alternatives such as a wedge cushion can help to lessen the patient's risk of falling. According to the administrators that have adopted policies of restraint-free, or at least drastic restraint reduction, creativity plays an important role in the restraint-free environment. Increased social activities, electronic alarm systems at the patient's door, reclining chairs, and lower beds all have been used to reduce restraint use while maintaining a more dignified and comfortable life for the institutionalized elderly. The reduction and possible restraint-free care environment is essential to providing the highest quality of life for the elderly residing in health care facilities.

Medigap Insurance: Cost, Confusion, and Criminality, Madison, WI, December 11, 1989, Hon. Herb Kohl, Presiding

Witnesses

Wilma Blum, medigap consumer, Monticello, WI
Harold Halfin, senior volunteer/benefit specialist, Dunn County Office on Aging
Troy Keeling, director, Western Wisconsin Area Agency on Aging, Eau Claire, WI
State Senator Russ Feingold
Timothy Cullen, vice president, Blue Cross and Blue Shield United of Wisconsin
David Becker, Arneson/Becker Insurance, Mount Horeb, WI
Geralyn Hawkins, Benefits Hotline Specialist, Wisconsin Board on Aging and Long-Term Care
Robert D. Haase, Wisconsin State Commissioner of Insurance
Bette Johnson, president, Coalition of Wisconsin Aging Groups
Betsy Abramson, legal advocate, Center for Public Representation

Issues Raised and Testimony Summary

The purpose of the hearing was to investigate the rising cost of Medigap insurance, particularly in light of the recent repeal of the Medicare Catastrophic Coverage Act, as well as the confusion over coverage and benefit options, the prevalence of fraudulent and deceptive insurance marketing practices, and the enforcement of the 1980 Baucus amendments. The State of Wisconsin was a pioneer in insurance regulation and protection of Medigap consumers. It was hoped that the hearing would yield policy recommendations that would benefit other States and perhaps eventually could be considered for Federal legislation.

While Medicare supplemental insurance costs in the state of Wisconsin have been relatively stable over recent years, particularly when contrasted with those of other States, it was found that the 1980 Baucus amendments are not being enforced. It was also found that despite the implementation of model regulations of the National Association of Insurance Commissioners, the ability of consumers to help control costs by comparative purchasing practices is severely limited. Elderly consumers and their advocates testified that fraudulent and deceptive practices are widespread and that objective, comparable information about Medigap policies is seriously needed. Insurance industry representatives echoed those concerns and called for increased federal regulation and more stringent enforcement of existing laws.

Supplement 2

COMMITTEE PRINTS ISSUED BY THE SPECIAL COMMITTEE ON AGING IN 1989

Protecting Older Americans Against Overpayment of Income Taxes, Serial No. 101-A

Compilation of the Older Americans Act of 1965, As Amended Through December 31, 1988, Serial No. 101-B.

Publications List, Serial No. 101-C.

Prescription Drug Prices: Are We Getting Our Money's Worth? August 1989, Serial No. 101-D.

Aging America: Trends and Projections, September 1989, Serial No. 101-E.

Skyrocketing Prescription Drug Prices: Turning a Bad Deal Into a Fair Deal, January 1990, Serial No. 101-F.

Protecting Older Americans Against Overpayment of Income Taxes, January 1990, Serial No. 101-G.

Untie the Elderly: Quality Care Without Restraints, February 1990, Serial No. 101-H.

Reauthorization of the Older Americans Act, February 1990, Serial No. 101-I.

Supplement 3

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Supplement 4

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The Special Committee on Aging, under the direction of its Chairman, publishes committee prints, reports, and transcriptions of its hearings each year. These documents are listed chronologically by year, beginning with reports and committee prints, and followed by hearings.

Copies of committee hearings and reports are available from the committee and from the Government Printing Office. The date of publication and the number of copies you would like generally determine which office you should contact in requesting a publication.

The following are guidelines for ordering copies of committee publications:

—Single copies of publications printed after January 1985 can be obtained from the committee.

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While a single copy of a publication is available, free of charge, from the committee, the Government Printing Office charges for publications.

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Government Printing Office
Washington, D.C. 20402
(202) 783-3238

REPORTS

Developments in Aging, 1959 to 1963, Report No. 8, February 1963.*
Developments in Aging, 1963 and 1964, Report No. 124, March 1965.*
Developments in Aging, 1965, Report No. 1073, March 1966.*
Developments in Aging, 1966, Report No. 169, April 1967.*
Developments in Aging, 1967, Report No. 1098, April 1968.*
Developments in Aging, 1968, Report No. 91-119, April 1969.*
Developments in Aging, 1969, Report No. 91-875, May 1970.*
Developments in Aging, 1970, Report No. 92-46, March 1971.*
Developments in Aging: 1971 and January-March 1972, Report No. 92-784, May 1972.*
Developments in Aging: 1972 and January-March 1973, Report No. 93-147, May 1973.*
Developments in Aging: 1973 and January-March 1974, Report No. 93-846, May 1974.*
Developments in Aging: 1974 and January-April 1975, Report No. 94-250, June 1975.*
Developments in Aging: 1975 and January-May 1976—Part 1, Report No. 94-998, June 1976.*
Developments in Aging: 1975 and January-May 1976—Part 2, Report No. 94-998, June 1976.*
Developments in Aging: 1976—Part 1, Report No. 95-88, April 1977.*
Developments in Aging: 1976—Part 2, Report No. 95-88, April 1977.*
Developments in Aging: 1977—Part 1, Report No. 95-771, April 1978.*
Developments in Aging: 1977—Part 2, Report No. 95-771, April 1978.*
Developments in Aging: 1978—Part 1, Report No. 96-55, March 1979.*
Developments in Aging: 1978—Part 2, Report No. 96-55, March 1979.*
Developments in Aging: 1979—Part 1, Report No. 96-613, February 1980.*
Developments in Aging: 1979—Part 2, Report No. 96-613, February 1980.*
Developments in Aging: 1980—Part 1, Report No. 97-62, May 1981.*
Developments in Aging: 1980—Part 2, Report No. 97-62, May 1981.*

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Developments in Aging: 1981—Volume 1, Report No. 97-314, March 1982.*
Developments in Aging: 1981—Volume 2, Report No. 97-314, March 1982.*
Developments in Aging: 1982—Volume 1, Report No. 98-13, February 1983.*
Developments in Aging: 1982—Volume 2, Report No. 98-13, February 1983.*
Developments in Aging: 1983—Volume 1, Report No. 98-360, February 1984—$13.*
Developments in Aging: 1983—Volume 2, Report No. 98-360, February 1984—$8.*
Developments in Aging: 1984—Volume 1, Report No. 99-5, February 1985.—$9.*
Developments in Aging: 1984—Volume 2, Report No. 99-5, February 1985—$8.*
Developments in Aging: 1985—Volume 1, Report No. 99-242, February 1986.
Developments in Aging: 1985—Volume 2—Appendixes, Report No. 99-242, February 1986.*
Developments in Aging: 1985—Volume 3—America in Transition: An Aging Society.*
Developments in Aging: 1986—Volume 1, Report No. 100-9, February 1987.
Developments in Aging: 1986—Volume 2, Appendixes, Report No. 100-9, February 1987.*
Developments in Aging: 1986—Volume 3—America in Transition: An Aging Society, Report No. 100-9, February 1987.*
Developments in Aging: 1987—Volume 1, Report No. 100-291, February 1988.
Developments in Aging: 1987—Volume 2—Appendixes, Report No. 100-291, February 1988.*
Developments in Aging: 1987—Volume 3—The Long-Term Care Challenge, Report No. 100-291, February 1988.
Developments in Aging: 1988—Volume 1—Report No. 101-4, February 1989.
Developments in Aging: 1988—Volume 2—Appendixes, Report No. 101-4, February 1989.

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COMMITTEE PRINTS

1961

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 1961.*

The 1961 White House Conference on Aging, basic policy statements and recommendations, committee print, May 1961.*

New Population Facts on Older Americans, 1960, committee print, May 1961.*

Basic Facts on the Health and Economic Status of Older Americans, staff report, committee print, June 1961.*

Health and Economic Conditions of the American Aged, committee print, June 1961.*

State Action To Implement Medical Programs for the Aged, committee print, June 1961.*

A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.*

Mental Illness Among Older Americans, committee print, September 1961.*

1962

Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 1962.*

Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 1962.*

Statistics on Older People: Some Current Facts About the Nation's Older People, June 1962.*

Performance of the States: 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print, June 1962.*

Housing for the Elderly, committee print, August 1962.*

Some Current Facts About the Nation's Older People, October 1962.*

1963

A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, committee print, June 1963.*

Medical Assistance for the Aged: The Kerr-Mills Program, 1960–63, committee print, October 1963.*

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1964

Blue Cross and Private Health Insurance Coverage of Older Americans, committee print, July 1964.*

Increasing Employment Opportunities for the Elderly—Recommendations and Comment, committee print, August 1964.*

Services for Senior Citizens—Recommendations and Comment, Report No. 1542, September 1964.*

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1963-64, committee print, October 1964.*

1965

Frauds and Deceptions Affecting the Elderly—Investigations, Findings, and Recommendations: 1964, committee print, January 1965.*

Extending Private Pension Coverage, committee print, June 1965.*

Health Insurance and Related Provisions of Public Law 89-97, The Social Security Amendments of 1965, committee print, October 1965.*

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, committee print, November 1965.*

1966

Services to the Elderly on Public Assistance, committee print, March 1966.*

The War on Poverty As It Affects Older Americans, Report No. 1287, June 1966.*

Needs for Services Revealed by Operation Medicare Alert, committee print, October 1966.*

Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 1966.*

Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print, December 1966.*

1967

Reduction of Retirement Benefits Due to Social Security Increases, committee print, August 1967.*

1969

Economics of Aging: Toward a Full Share in Abundance, committee print, March 1969.* [1]

Homeownership Aspects of the Economics of Aging, working paper, factsheet, July 1969.* [1]

Health Aspects of the Economics of Aging, committee print, July 1969 (revised).* [1]

Social Security for the Aged: International Perspectives, committee print, August 1969.* [1]

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[1] Working paper incorporated as an appendix to the hearing.

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Employment Aspects of the Economics of Aging, committee print, December 1969.* [1]

1970

Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, committee print, January 1970.* [1]

The Stake of Today's Workers in Retirement Security, committee print, April 1970.* [1]

Legal Problems Affecting Older Americans, committee print, August 1970.* [1]

Income Tax Overpayments by the Elderly, Report No. 91-1464, December 1970.*

Older Americans and Transportation: A Crisis in Mobility, Report No. 91-1520, December 1970.*

Economics of Aging: Toward a Full Share in Abundance, Report No. 91-1548, December 1970.*

1971

Medicare, Medicaid Cutbacks in California, working paper, factsheet, May 10, 1971.*

The Nation's Stake in the Employment of Middle-Aged and Older Persons, committee print, July 1971.*

The Administration on Aging—Or a Successor?, committee print, October 1971.*

Alternatives to Nursing Home Care: A Proposal, committee print, October 1971.*

Mental Health Care and the Elderly: Shortcomings in Public Policy, Report No. 92-433, November 1971.*

The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States, Report No. 92-450, November 1971.*

Advisory Council on the Elderly American Indian, committee print, November 1971.*

Elderly Cubans in Exile, committee print, November 1971.*

A Pre-White House Conference on Aging: Summary of Developments and Data, Report No. 92-505, November 1971.*

Research and Training in Gerontology, committee print, November 1971.*

Making Services for the Elderly Work: Some Lessons From the British Experience, committee print, November 1971.*

1971 White House Conference on Aging, a report to the delegates from the conference sections and special concerns sessions, Document No. 92-53, December 1971.*

1972

Home Health Services in the United States, committee print, April 1972.*

Proposals To Eliminate Legal Barriers Affecting Elderly Mexican-Americans, committee print, May 1972.*

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*NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees, committee print, May 1972.*

Action on Aging Legislation in 92d Congress, committee print, October 1972.*

Legislative History of the Older Americans Comprehensive Services Amendments of 1972, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, December 1972.*

1973

The Rise and Threatened Fall of Service Programs for the Elderly, committee print, March 1973.*

Housing for the Elderly: A Status Report, committee print, April 1973.*

Older Americans Comprehensive Services Amendments of 1973, committee print, June 1973.*

Home Health Services in the United States: A Working Paper on Current Status, committee print, July 1973.*

Economics of Aging: Toward a Full Share in Abundance, index to hearings and report, committee print, July 1973.*

Research on Aging Act, 1973, Report No. 93-299, committee print, July 1973.*

Post-White House Conference on Aging Reports, 1973, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, September 1973.*

Improving the Age Discrimination Law, committee print, September 1973.*

1974

The Proposed Fiscal 1975 Budget: What It Means for Older Americans, committee print, February 1974.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, February 1974.*

Developments and Trends in State Programs and Services for the Elderly, committee print, November 1974.*

Nursing Home Care in the United States: Failure in Public Policy:*
- Introductory Report, Report No. 93-1420, November 1974.
- Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," committee print, December 1974.
- Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," committee print, January 1975.
- Supporting Paper No. 3, "Doctors in Nursing Homes: The Shunned Responsibility," committee print, February 1975.
- Supporting Paper No. 4, "Nurses in Nursing Homes: The Heavy Burden (the Reliance on Untrained and Unlicensed Personnel)," committee print, April 1975.
- Supporting Paper No. 5, "The Continuing Chronicle of Nursing Home Fires," committee print, August 1975.

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Supporting Paper No. 6, "What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care," committee print, September 1975.

Supporting Paper No. 7, "The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry)," committee print, March 1976.

Private Health Insurance Supplementary to Medicare, committee print, December 1974.*

1975

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1975.*

Senior Opportunities and Services (Directory of Programs), committee print, February 1975.*

Action on Aging Legislation in 93d Congress, committee print, February 1975.*

The Proposed Fiscal 1976 Budget: What It Means for Older Americans, committee print, February 1975.*

Future Directions in Social Security, Unresolved Issues: An Interim Staff Report, committee print, March 1975.*

Women and Social Security: Adapting to a New Era, working paper, committee print, October 1975.*

Congregate Housing for Older Adults, Report No. 94-478, November 1975.*

1976

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1976.*

The Proposed Fiscal 1977 Budget: What It Means for Older Americans, committee print, February 1976.*

Fraud and Abuse Among Clinical Laboratories, Report No. 94-944, June 1976.*

Recession's Continuing Victim: The Older Worker, committee print, July 1976.*

Fraud and Abuse Among Practitioners Participating in the Medicaid Program, committee print, August 1976.*

Adult Day Facilities for Treatment, Health Care, and Related Services, committee print, September 1976.*

Termination of Social Security Coverage: The Impact on State and Local Government Employees, committee print, September 1976.*

Witness Index and Research Reference, committee print, November 1976.*

Action on Aging Legislation in 94th Congress, committee print, November 1976.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1976.*

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1977

The Proposed Fiscal 1978 Budget: What It Means for Older Americans, committee print, March 1977.*

Kickbacks Among Medicaid Providers, Report No. 95-320, June 1977.*

Protective Services for the Elderly, committee print, July 1977.*

The Next Steps in Combating Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy, committee print, August 1977.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1977.*

1978

The Proposed Fiscal 1979 Budget: What It Means for Older Americans, committee print, February 1978.*

Paperwork and the Older Americans Act: Problems of Implementing Accountability, committee print, June 1978.*

Single Room Occupancy: A Need for National Concern, committee print, June 1978.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1978.*

Action on Aging Legislation in the 95th Congress, committee print, December 1978.*

1979

The Proposed Fiscal 1980 Budget: What It Means for Older Americans, committee print, February 1979.*

Energy Assistance Programs and Pricing Policies in the 50 States To Benefit Elderly, Disabled, or Low-Income Households, committee print, October 1979.*

Witness Index and Research Reference, committee print, November 1979.*

1980

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1980.*

The Proposed Fiscal 1981 Budget: What It Means for Older Americans, committee print, February 1980.*

Emerging Options for Work and Retirement Policy (An Analysis of Major Income and Employment Issues With an Agenda for Research Priorities), committee print, June 1980.*

Summary of Recommendations and Surveys on Social Security and Pension Policies, committee print, October 1980.*

Innovative Developments in Aging: State Level, committee print, October 1980.*

State Offices on Aging: History and Statutory Authority, committee print, December 1980.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1980.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

State and Local Government Terminations of Social Security Coverage, committee print, December 1980.*

1981

The Proposed Fiscal Year 1982 Budget: What It Means for Older Americans, committee print, April 1981.*
Action on Aging Legislation in the 96th Congress, committee print, April 1981.*
Energy and the Aged, committee print, August 1981.*
1981 Federal Income Tax Legislation: How It Affects Older Americans and Those Planning for Retirement, committee print, August 1981.*
Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, committee print, September 1981.*
Toward a National Older Worker Policy, committee print, September 1981.*
Crime and the Elderly—What You Can Do, committee print, September 1981.*
Social Security in Europe: The Impact of an Aging Population, committee print, December 1981.*
Background Materials Relating to Office of Inspector General, Department of Health and Human Services Efforts To Combat Fraud, Waste, and Abuse, committee print, December 1981.*
Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1981.*
A Guide to Individual Retirement Accounts (IRA's), committee print, December 1981, stock No. 052-070-05666-5—$2.*

1982

Social Security Disability: Past, Present, and Future, committee print, March 1982.*
The Proposed Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, March 1982.*
Linkages Between Private Pensions and Social Security Reform, committee print, April 1982.*
Health Care Expenditures for the Elderly: How Much Protection Does Medicare Provide?, committee print, April 1982.*
Turning Home Equity Into Income for Older Homeowners, committee print, July 1982, stock No. 052-070-05753-0—$1.25.*
Aging and the Work Force: Human Resource Strategies, committee print, August 1982.*
Fraud, Waste, and Abuse in the Medicare Pacemaker Industry, committee print, September 1982, stock No. 052-070-05777-7—$6.*
Congressional Action on the Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, November 1982.*
Equal Employment Opportunity Commission Enforcement of the Age Discrimination in Employment Act: 1979 to 1982, committee print, November 1982.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1982.*

1983

Consumer Frauds and Elderly Persons: A Growing Problem, committee print, February 1983, stock No. 052-070-05823-4—$4.50.*
Action on Aging Legislation in the 97th Congress, committee print, March 1983.*
Prospects for Medicare's Hospital Insurance Trust Fund, committee print, March 1983.*
The Proposed Fiscal Year 1984 Budget: What It Means for Older Americans, committee print, March 1983.*
You and Your Medicines: Guidelines for Older Americans, committee print, June 1983.*
Heat Stress and Older Americans: Problems and Solutions, committee print, July 1983.*
Current Developments in Prospective Reimbursement Systems for Financing Hospital Care, committee print, October 1983.*
Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1983.*

1984

Medicare: Paying the Physician—History, Issues, and Options, committee print, March 1984.
Older Americans and the Federal Budget: Past, Present, and Future, committee print, April 1984.*
Medicare and the Health Cost of Older Americans: The Extent and Effects of Cost Sharing, committee print, April 1984, Stock No. 052-050-05916-8, $2.
The Supplemental Security Income Program: A 10-Year Overview, committee print, May 1984, Stock No. 052-050-05928-1, $6.50.*
Long-Term Care in Western Europe and Canada: Implications for the United States, committee print, July 1984.
Turning Home Equity Into Income for Older Americans, committee print, July 1984, stock No. 052-070-05753-3, $1.25.
The Employee Retirement Income Security Act of 1974: The First Decade, committee print, August 1984, stock No. 052-070-05950-8, $5,50.
The Costs of Employing Older Workers, committee print, September 1984.*
Rural and Small-City Elderly, committee print, September 1984.*
Section 202 Housing for the Elderly and Handicapped: A National Survey, committee print, December 1984.*
Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1984, stock No. 052-070-05984-2, $1.25.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

1985

Health and Extended Worklife, committee print, February 1985.
Personnel Practices for an Aging Workforce: Private-Sector Examples, committee print, February 1985.*
10th Anniversary of the Employee Retirement Income Security Act of 1974, committee print, April 1985.
Publications list, committee print, April 1985.*
Compilation of the Older Americans Act of 1965 and Related Provisions of Law, committee print, Serial No. 99-A, June 1985.
America In Transition: An Aging Society, 1984-85 Edition, committee print, Serial No. 99-B, June 1985.*
Fifty Years of Social Security: Past Achievements and Future Challenges, committee print, Serial No. 99-C, August 1985.
How Older Americans Live: An Analysis of Census Data, committee print, Serial No. 99-D, October 1985.*
Congressional Briefing on the 50th Anniversary of Social Security, committee print, Serial No. 99-E, August 1985.

1986

Protecting Older Americans Against Overpayment of Income Taxes, committee print, Serial No. 99-F, January 1986.*
The Cost of Mandating Pension Accruals for Older Workers, committee print, Serial No. 99-G, February 1986.
The Impact of Gramm-Rudman-Hollings on Programs Serving Older Americans: Fiscal Year 1986, committee print, Serial No. 99-H, February 1986.*
Alternative Budgets for Fiscal Year 1987: Impact on Older Americans, committee print, Serial No. 99-I, May 1986, stock No. 552-070-00760-1, $1.75.
Nursing Home Care: The Unfinished Agenda, committee print, Serial No. 99-J, May 1986, stock No. 052-070-06155-3, $1.50.
Hazards in Reuse of Disposable Dialysis Devices, committee print, Serial No. 99-K, October 1986, stock No. 552-070-01074-2, $14.
The Health Status and Health Care Needs of Older Americans, committee print, Serial No. 99-L, October 1986, stock No. 552-070-01493-4, $1.50.
A Matter of Choice: Planning Ahead for Health Care Decisions, committee print, Serial No. 99-M, December 1986.
Hazards in Reuse of Disposable Dialysis Devices—Appendix, committee print, Serial No. 99-N, December 1986.*

1987

Helping Older Americans To Avoid Overpayment of Income Taxes, committee print, Serial No. 100-A.*
Publications List, committee print, March 1987, Serial No. 100-B.
Older Americans Act Amendments of 1987: A Summary of Provisions, committee print, December 1987, Serial No. 100-C.

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

1988

Helping Older Americans To Avoid Overpayment of Income Taxes, committee print, January 1988, Serial No. 100-D.

Publications List, committee print, February 1988, Serial No. 100-E.

Compilation of the Domestic Volunteer Service Act of 1973, April 1988, Serial No. 100-F.

The President's Fiscal Year 1989 Budget Proposal: How it Would Affect Programs for Older Americans, committee print, April 1988, Serial No. 100-G.

Home Care at the Crossroads, committee print, April 1988, Serial No. 100-H.

Health Insurance and the Uninsured: Background and Analysis, joint committee print, May 1988, Serial No. 100-I.

Legislative Agenda for an Aging Society: 1988 and Beyond, joint committee print, June 1988, Serial No. 100-J.

Medicare Physician Reimbursement: Issues and Options, committee print, September 1988, Serial No. 100-L.

Medicare's New Prescription Drug Coverage: A Big Step Forward, But Problems Still Exist, committee print, October 1988, Serial No. 100-M.

Rural Health Care Challenge, committee print, October 1988, Serial No. 100-N.

Insuring the Uninsured: Options and Analysis, joint committee print, December 1988, Serial No. 100-O.

Costs and Effects of Extending Health Insurance Coverage, joint committee print, December 1988, Serial No. 100-P.

EEOC Headquarters Officials Punish District Director for Exposing Headquarters Mismanagement, committee print, December 1988, Serial No. 100-Q.

1989

Protecting Older Americans Against Overpayment of Income Taxes, committee print, Serial No. 101-A, January 1989.

Compilation of the Older Americans Act of 1965, As Amended Through December 31, 1988, joint committee print, Serial No. 101-B, March 1989.

Publications List, Serial No. 101-C.

Prescription Drug Prices: Are We Getting Our Money's Worth? August 1989, Serial No. 101-D.

Aging America: Trends and Projections, September 1989, Serial No. 101-E.

Skyrocketing Prescription Drug Prices: Turning a Bad Deal Into a Fair Deal, January 1990, Serial No. 101-F.

Protecting Older Americans Against Overpayment of Income Taxes, January 1990, Serial No. 101-G.

Untie the Elderly: Quality Care Without Restraints, February 1990, Serial No. 101-H.

Reauthorization of the Older Americans Act, February 1990, Serial No. 101-I.

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

HEARINGS

- Retirement Income of the Aging:*
  - Part 1. Washington, D.C., July 12 and 13, 1961.
  - Part 2. St. Petersburg, Fla., November 6, 1961.
  - Part 3. Port Charlotte, Fla., November 7, 1961.
  - Part 4. Sarasota, Fla., November 8, 1961.
  - Part 5. Springfield, Mass., November 29, 1961.
  - Part 6. St. Joseph, Mo., December 11, 1961.
  - Part 7. Hannibal, Mo., December 13, 1961.
  - Part 8. Cape Girardeau, Mo., December 15, 1961.
  - Part 9. Daytona Beach, Fla., February 14, 1962.
  - Part 10. Fort Lauderdale, Fla., February 15, 1962.
- Housing Problems of the Elderly:*
  - Part 1. Washington, D.C., August 22 and 23, 1961.
  - Part 2. Newark, N.J., October 16, 1961.
  - Part 3. Philadelphia, Pa., October 18, 1961.
  - Part 4. Scranton, Pa., November 14, 1961.
  - Part 5. St. Louis, Mo., December 8, 1961.
- Problems of the Aging:*
  - Part 1. Washington, D.C., August 23 and 24, 1961.
  - Part 2. Trenton, N.J., October 23, 1961.
  - Part 3. Los Angeles, Calif., October 24, 1961.
  - Part 4. Las Vegas, Nev., October 25, 1961.
  - Part 5. Eugene, Oreg., November 8, 1961.
  - Part 6. Pocatello, Idaho, November 13, 1961.
  - Part 7. Boise, Idaho, November 15, 1961.
  - Part 8. Spokane, Wash., November 17, 1961.
  - Part 9. Honolulu, Hawaii, November 27, 1961.
  - Part 10. Lihue, Hawaii, November 29, 1961.
  - Part 11. Wailuku, Hawaii, November 30, 1961.
  - Part 12. Hilo, Hawaii, December 1, 1961.
  - Part 13. Kansas City, Mo., December 6, 1961.
- Nursing Homes:*
  - Part 1. Portland, Oreg., November 6, 1961.
  - Part 2. Walla Walla, Wash., November 10, 1961.
  - Part 3. Hartford, Conn., November 20, 1961.
  - Part 4. Boston, Mass., December 1, 1961.
  - Part 5. Minneapolis, Minn., December 4, 1961.
  - Part 6. Springfield, Mo., December 12, 1961.
- Relocation of Elderly People:*
  - Part 1. Washington, D.C., October 22 and 23, 1962.
  - Part 2. Newark, N.J., October 26, 1962.
  - Part 3. Camden, N.J., October 29, 1962.
  - Part 4. Portland, Oreg., December 3, 1962.

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Relocation of Elderly People—Continued
    Part 5. Los Angeles, Calif., December 5, 1962.
    Part 6. San Francisco, Calif., December 7, 1962.
Frauds and Quackery Affecting the Older Citizen:*
    Part 1. Washington, D.C., January 15, 1963.
    Part 2. Washington, D.C., January 16, 1963.
    Part 3. Washington, D.C., January 17, 1963.
Housing Problems of the Elderly:*
    Part 1. Washington, D.C., December 11, 1963.
    Part 2. Los Angeles, Calif., January 9, 1964.
    Part 3. San Francisco, Calif., January 11, 1964.
Long-Term Institutional Care for the Aged, Washington, D.C., December 17 and 18, 1963.*
Increasing Employment Opportunities for the Elderly:*
    Part 1. Washington, D.C., December 19, 1963.
    Part 2. Los Angeles, Calif., January 10, 1964.
    Part 3. San Francisco, Calif., January 13, 1964.
Health Frauds and Quackery:*
    Part 1. San Francisco, Calif., January 13, 1964.
    Part 2. Washington, D.C., March 9, 1964.
    Part 3. Washington, D.C., March 10, 1964.
    Part 4A. Washington, D.C., April 6, 1964 (morning).
    Part 4B. Washington, D.C., April 6, 1964 (afternoon).
Services for Senior Citizens:*
    Part 1. Washington, D.C., January 16, 1964.
    Part 2. Boston, Mass., January 20, 1964.
    Part 3. Providence, R.I., January 21, 1964.
    Part 4. Saginaw, Mich., March 2, 1964.
Blue Cross and Other Private Health Insurance for the Elderly:*
    Part 1. Washington, D.C., April 27, 1964.
    Part 2. Washington, D.C., April 28, 1964.
    Part 3. Washington, D.C., April 29, 1964.
    Part 4A. Appendix.
    Part 4B. Appendix.
Deceptive or Misleading Methods in Health Insurance Sales, Washington, D.C., May 4, 1964.*
Nursing Homes and Related Long-Term Care Services:*
    Part 1. Washington, D.C., May 5, 1964.
    Part 2. Washington, D.C., May 6, 1964.
    Part 3. Washington, D.C., May 7, 1964.
Interstate Mail Order Land Sales:*
    Part 1. Washington, D.C., May 18, 1964.
    Part 2. Washington, D.C., May 19, 1964.
    Part 3. Washington, D.C., May 20, 1964.
Preneed Burial Service, Washington, D.C., May 19, 1964.*
Conditions and Problems in the Nation's Nursing Homes:*
    Part 1. Indianapolis, Ind., February 11, 1965.
    Part 2. Cleveland, Ohio, February 15, 1965.
    Part 3. Los Angeles, Calif., February 17, 1965.
    Part 4. Denver, Colo., February 23, 1965.

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Conditions and Problems in the Nation's Nursing Homes—Continued
  Part 5. New York, N.Y., August 2 and 3, 1965.
  Part 6. Boston, Mass., August 9, 1965.
  Part 7. Portland, Maine, August 13, 1965.
Extending Private Pension Coverage:*
  Part 1. Washington, D.C., March 4, 1965.
  Part 2. Washington, D.C., March 5 and 10, 1965.
The War on Poverty As It Affects Older Americans:*
  Part 1. Washington, D.C., June 16 and 17, 1965.
  Part 2. Newark, N.J., July 10, 1965.
  Part 3. Washington, D.C., January 19 and 20, 1966.
Services to the Elderly on Public Assistance:*
  Part 1. Washington, D.C., August 18 and 19, 1965.
  Part 2. Appendix.
Needs for Services Revealed by Operation Medicare Alert, Washington, D.C., June 2, 1966.*
Tax Consequences of Contributions to Needy Older Relatives, Washington, D.C., June 15, 1966.*
Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, Washington, D.C., September 20, 21, and 22, 1966.*
Consumer Interests of the Elderly:*
  Part 1. Washington, D.C., January 17 and 18, 1967.
  Part 2. Tampa, Fla., February 3, 1967.
Reduction of Retirement Benefits Due to Social Security Increases, Washington, D.C., April 24 and 25, 1967.*
Retirement and the Individual:*
  Part 1. Washington, D.C., June 7 and 8, 1967.
  Part 2. Ann Arbor, Mich., July 26, 1967.
Costs and Delivery of Health Services to Older Americans:*
  Part 1. Washington, D.C., June 22 and 23, 1967.
  Part 2. New York, N.Y., October 19, 1967.
  Part 3. Los Angeles, Calif., October 16, 1968.
Rent Supplement Assistance to the Elderly, Washington, D.C., July 11, 1967.*
Long-Range Program and Research Needs in Aging and Related Fields, Washington, D.C., December 5 and 6, 1967.*
Hearing Loss, Hearing Aids, and the Elderly, Washington, D.C., July 18 and 19, 1968.*
Usefulness of the Model Cities Program to the Elderly:*
  Part 1. Washington, D.C., July 23, 1968.
  Part 2. Seattle, Wash., October 14, 1968.
  Part 3. Ogden, Utah, October 24, 1968.
  Part 4. Syracuse, N.Y., December 9, 1968.
  Part 5. Atlanta, Ga., December 11, 1968.
  Part 6. Boston, Mass., July 11, 1969.
  Part 7. Washington, D.C., October 14 and 15, 1969.
Adequacy of Services for Older Workers, Washington, D.C., July 24, 25, and 29, 1968.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans: *
  Part 1. Los Angeles, Calif., December 17, 1968.
  Part 2. El Paso, Tex., December 18, 1968.
  Part 3. San Antonio, Tex., December 19, 1968.
  Part 4. Washington, D.C., January 14 and 15, 1969.
  Part 5. Washington, D.C., November 20 and 21, 1969.
Economics of Aging: Toward a Full Share in Abundance:*
  Part 1. Washington, D.C., survey hearing, April 29 and 30, 1969.
  Part 2. Ann Arbor, Mich., consumer aspects, June 9, 1969.
  Part 3. Washington, D.C., health aspects, July 17 and 18, 1969.
  Part 4. Washington, D.C., homeownership aspects, July 31 and August 1, 1969.
  Part 5. Paramus, N.J., central suburban area, August 14, 1969.
  Part 6. Cape May, N.J., retirement community, August 15, 1969.
  Part 7. Washington, D.C., international perspectives, August 25, 1969.
  Part 8. Washington, D.C., national organizations, October 29, 1969.
  Part 9. Washington, D.C., employment aspects, December 18 and 19, 1969.
  Part 10A. Washington, D.C., pension aspects, February 17, 1970.
  Part 10B. Washington, D.C., pension aspects, February 18, 1970.
  Part 11. Washington, D.C., concluding hearing, May 4, 5, and 6, 1970.
The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns, Washington, D.C., July 25, 1969.*
Trends in Long-Term Care:*
  Part 1. Washington, D.C., July 30, 1969.
  Part 2. St. Petersburg, Fla., January 9, 1970.
  Part 3. Hartford, Conn., January 15, 1970.
  Part 4. Washington, D.C. (Marietta, Ohio, fire), February 9, 1970.
  Part 5. Washington, D.C. (Marietta, Ohio, fire), February 10, 1970.
  Part 6. San Francisco, Calif., February 12, 1970.
  Part 7. Salt Lake City, Utah, February 13, 1970.
  Part 8. Washington, D.C., May 7, 1970.
  Part 9. Washington, D.C. (Salmonella), August 19, 1970.
  Part 10. Washington, D.C. (Salmonella), December 14, 1970.
  Part 11. Washington, D.C., December 17, 1970.
  Part 12. Chicago, Ill., April 2, 1971.
  Part 13. Chicago, Ill., April 3, 1971.
  Part 14. Washington, D.C., June 15, 1971.
  Part 15. Chicago, Ill., September 14, 1971.
  Part 16. Washington, D.C., September 29, 1971.
  Part 17. Washington, D.C., October 14, 1971.

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Trends in Long-Term Care—Continued
  Part 18. Washington, D.C., October 28, 1971.
  Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971.
  Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971.
  Part 20. Washington, D.C., August 10, 1972.
  Part 21. Washington, D.C., October 10, 1973.
  Part 22. Washington, D.C., October 11, 1973.
  Part 23. New York, N.Y., January 21, 1975.
  Part 24. New York, N.Y., February 4, 1975.
  Part 25. Washington, D.C., February 19, 1975.
  Part 26. Washington, D.C., December 9, 1975.
  Part 27. New York, N.Y., March 19, 1976.
Older Americans in Rural Areas:*
  Part 1. Des Moines, Iowa, September 8, 1969.
  Part 2. Majestic-Freeburn, Ky., September 12, 1969.
  Part 3. Fleming, Ky., September 12, 1969.
  Part 4. New Albany, Ind., September 16, 1969.
  Part 5. Greenwood, Miss., October 9, 1969.
  Part 6. Little Rock, Ark., October 10, 1969.
  Part 7. Emmett, Idaho, February 24, 1970.
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  Part 9. Washington, D.C., May 26, 1970.
  Part 10. Washington, D.C., June 2, 1970.
  Part 11. Dogbone-Charleston, W. Va., October 27, 1970.
  Part 12. Wallace-Clarksburg, W. Va., October 28, 1970.
Income Tax Overpayments by the Elderly, Washington, D.C., April 15, 1970.*
Sources of Community Support for Federal Programs Serving Older Americans:*
  Part 1. Ocean Grove, N.J., April, 18, 1970.
  Part 2. Washington, D.C., June 8 and 9, 1970.
Legal Problems Affecting Older Americans:*
  Part 1. St. Louis, Mo., August 11, 1970.
  Part 2. Boston, Mass., April 30, 1971.
Evaluation of Administration on Aging and Conduct of White House Conference on Aging:*
  Part 1. Washington, D.C., March 25, 1971.
  Part 2. Washington, D.C., March 29, 1971.
  Part 3. Washington, D.C., March 30, 1971.
  Part 4. Washington, D.C., March 31, 1971.
  Part 5. Washington, D.C., April 27, 1971.
  Part 6. Orlando, Fla., May 10, 1971.
  Part 7. Des Moines, Iowa, May 13, 1971.
  Part 8. Boise, Idaho, May 28, 1971.
  Part 9. Casper, Wyo., August 13, 1971.
  Part 10. Washington, D.C., February 3, 1972.
Cutbacks in Medicare and Medicaid Coverage:*
  Part 1. Los Angeles, Calif., May 10, 1971.
  Part 2. Woonsocket, R.I., June 14, 1971.
  Part 3. Providence, R.I., September 20, 1971.

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Unemployment Among Older Workers: *
  Part 1. South Bend, Ind., June 4, 1971.
  Part 2. Roanoke, Ala., August 10, 1971.
  Part 3. Miami, Fla., August 11, 1971.
  Part 4. Pocatello, Idaho, August 27, 1971.
Adequacy of Federal Response to Housing Needs of Older Americans:*
  Part 1. Washington, D.C., August 2, 1971.
  Part 2. Washington, D.C., August 3, 1971.
  Part 3. Washington, D.C., August 4, 1971.
  Part 4. Washington, D.C., October 28, 1971.
  Part 5. Washington, D.C., October 29, 1971.
  Part 6. Washington, D.C., July 31, 1972.
  Part 7. Washington, D.C., August 1, 1972.
  Part 8. Washington, D.C., August 2, 1972.
  Part 9. Boston, Mass., October 2, 1972.
  Part 10. Trenton, N.J., January 17, 1974.
  Part 11. Atlantic City, N.J., January 18, 1974.
  Part 12. East Orange, N.J., January 19, 1974.
  Part 13. Washington, D.C., October 7, 1975.
  Part 14. Washington, D.C., October 8, 1975.
Flammable Fabrics and Other Fire Hazards to Older Americans, Washington, D.C., October 12, 1971.*
A Barrier-Free Environment for the Elderly and the Handicapped:*
  Part 1. Washington, D.C., October 18, 1971.
  Part 2. Washington, D.C., October 19, 1971.
  Part 3. Washington, D.C., October 20, 1971.
Death With Dignity: An Inquiry Into Related Public Issues:*
  Part 1. Washington, D.C., August 7, 1972.
  Part 2. Washington, D.C., August 8, 1972.
  Part 3. Washington, D.C., August 9, 1972.
Future Directions in Social Security:*
  Part 1. Washington, D.C., January 15, 1973.
  Part 2. Washington, D.C., January 22, 1973.
  Part 3. Washington, D.C., January 23, 1973.
  Part 4. Washington, D.C., July 25, 1973.
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  Part 6. Twin Falls, Idaho, May 16, 1974.
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  Part 13. San Francisco, Calif., May 15, 1975.
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  Part 18. Washington, D.C., October 22, 1975.

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Future Directions in Social Security—Continued
    Part 19. Washington, D.C., October 23, 1975.
    Part 20. Portland, Oreg., November 24, 1975.
    Part 21. Portland, Oreg., November 25, 1975.
    Part 22. Nashville, Tenn., December 6, 1975.
    Part 23. Boston, Mass., December 19, 1975.
    Part 24. Providence, R.I., January 26, 1976.
    Part 25. Memphis, Tenn., February 13, 1976.
Fire Safety in Highrise Buildings for the Elderly:*
    Part 1. Washington, D.C., February 27, 1973.
    Part 2. Washington, D.C., February 28, 1973.
Barriers to Health Care for Older Americans:*
    Part 1. Washington, D.C., March 5, 1973.
    Part 2. Washington, D.C., March 6, 1973.
    Part 3. Livermore Falls, Maine, April 23, 1973.
    Part 4. Springfield, Ill., May 16, 1973.
    Part 5. Washington, D.C., July 11, 1973.
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    Part 7. Coeur d'Alene, Idaho, August 4, 1973.
    Part 8. Washington, D.C., March 12, 1974.
    Part 9. Washington, D.C., March 13, 1974.
    Part 10. Price, Utah, April 20, 1974.
    Part 11. Albuquerque, N. Mex., May 25, 1974.
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    Part 13. Washington, D.C., June 25, 1974.
    Part 14. Washington, D.C., June 26, 1974.
    Part 15. Washington, D.C., July 9, 1974.
    Part 16. Washington, D.C., July 17, 1974.
Training Needs in Gerontology:*
    Part 1. Washington, D.C., June 19, 1973.
    Part 2. Washington, D.C., June 21, 1973.
    Part 3. Washington, D.C., March 7, 1975.
Hearing Aids and the Older American:*
    Part 1. Washington, D.C., September 10, 1973.
    Part 2. Washington, D.C., September 11, 1973.
Transportation and the Elderly: Problems and Progress:*
    Part 1. Washington, D.C., February 25, 1974.
    Part 2. Washington, D.C., February 27, 1974.
    Part 3. Washington, D.C., February 28, 1974.
    Part 4. Washington, D.C., April 9, 1974.
    Part 5. Washington, D.C., July 29, 1975.
    Part 6. Washington, D.C., July 12, 1977.
Improving Legal Representation for Older Americans:*
    Part 1. Los Angeles, Calif., June 14, 1974.
    Part 2. Boston, Mass., August 30, 1976.
    Part 3. Washington, D.C., September 28, 1976.
    Part 4. Washington, D.C., September 29, 1976.
Establishing a National Institute on Aging, Washington, D.C., August 1, 1974.*
The Impact of Rising Energy Costs on Older Americans:*
    Part 1. Washington, D.C., September 24, 1974.

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The Impact of Rising Energy Costs on Older Americans—Continued
  Part 2. Washington, D.C., September 25, 1974.
  Part 3. Washington, D.C., November 7, 1975.
  Part 4. Washington, D.C., April 5, 1977.
  Part 5. Washington, D.C., April 7, 1977.
  Part 6. Washington, D.C., June 28, 1977.
  Part 7. Missoula, Mont., February 14, 1979.
The Older Americans Act and the Rural Elderly, Washington, D.C., April 28, 1975.*
Examination of Proposed Section 202 Housing Regulations:*
  Part 1. Washington, D.C., June 6, 1975.
  Part 2. Washington, D.C., June 26, 1975.
The Recession and the Older Worker, Chicago, Ill., August 14, 1975.*
Medicare and Medicaid Frauds:*
  Part 1. Washington, D.C., September 26, 1975.
  Part 2. Washington, D.C., November 13, 1975.
  Part 3. Washington, D.C., December 5, 1975.
  Part 4. Washington, D.C., February 16, 1976.
  Part 5. Washington, D.C., August 30, 1976.
  Part 6. Washington, D.C., August 31, 1976.
  Part 7. Washington, D.C., November 17, 1976.
  Part 8. Washington, D.C., March 8, 1977.
  Part 9. Washington, D.C., March 9, 1977.
Mental Health and the Elderly, Washington, D.C., September 29, 1975.*
Proprietary Home Health Care (joint hearing with House Select Committee on Aging), Washington, D.C., October 28, 1975.*
Proposed USDA Food Stamp Cutbacks for the Elderly, Washington, D.C., November 3, 1975.*
The Tragedy of Nursing Home Fires: The Need for a National Commitment for Safety (joint hearing with House Select Committee on Aging), Washington, D.C., June 3, 1976.*
The Nation's Rural Elderly:*
  Part 1. Winterset, Iowa, August 16, 1976.
  Part 2. Ottumwa, Iowa, August 16, 1976.
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  Part 4. Ida Grove, Iowa, August 17, 1976.
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  Part 15. Pensacola, Fla., November 21, 1977.
  Part 16. Gainesville, Fla., November 22, 1977.
  Part 17. Champaign, Ill., December 13, 1977.

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Medicine and Aging: An Assessment of Opportunities and Neglect, New York, N.Y., October 13, 1976.*
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  Part 1. Washington, D.C., April 18, 1977.
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  Part 1. Washington, D.C., May 16, 1977.
  Part 2. Washington, D.C., May 17, 1977.
  Part 3. Washington, D.C., June 15, 1977.
  Part 4. Cleveland, Ohio, July 6, 1977.
  Part 5. Washington, D.C., September 21, 1977.
  Part 6. Holyoke, Mass., October 12, 1977.
  Part 7. Tallahassee, Fla., November 23, 1977.
  Part 8. Washington, D.C., April 17, 1978.
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  Part 2. Washington, D.C., June 29, 1978.
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  Part 1. Washington, D.C., July 17, 1978.
  Part 2. Washington, D.C., July 18, 1978.
  Part 3. Washington, D.C., July 19, 1978.
  Part 4. Washington, D.C., September 8, 1978.
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Vision Impairment Among Older Americans, Washington, D.C., August 3, 1978.*
The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and "Alternatives," Chicago, Ill., August 30, 1978.*
Condominiums and the Older Purchaser:*
  Part 1. Hallandale, Fla., November 28, 1978.
  Part 2. West Palm Beach, Fla., November 29, 1978.
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  Part 2. Oakland, Calif., December 4, 1978.
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Abuse of the Medicare Home Health Program, Miami, Fla., August 28, 1979.*

Occupational Health Hazards of Older Workers in New Mexico, Grants, N. Mex., August 30, 1979.*

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  Part 1. Akron, Ohio, August 30, 1979.
  Part 2. Washington, D.C., September 13, 1979.
  Part 3. Pennsauken, N.J., May 23, 1980.
  Part 4. Washington, D.C., July 25, 1980.

Regulations To Implement the Comprehensive Older Americans Act Amendments of 1978:*
  Part 1. Washington, D.C., October 18, 1979.
  Part 2. Washington, D.C., March 24, 1980.

Medicare Reimbursement for Elderly Participation in Health Maintenance Organizations and Health Benefit Plans, Philadelphia, Pa., October 29, 1979.*

Energy and the Aged: A Challenge to the Quality of Life in a Time of Declining Energy Availability, Washington, D.C., November 26, 1979.*

Adapting Social Security to a Changing Work Force, Washington, D.C., November 28, 1979.*

Aging and Mental Health: Overcoming Barriers to Service:*
  Part 1. Little Rock, Ark., April 4, 1980.
  Part 2. Washington, D.C., May 22, 1980.

Rural Elderly—The Isolated Population: A Look at Services in the 80's, Las Vegas, N. Mex., April 11, 1980.*

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  Part 1. Washington, D.C., April 24, 1980.
  Part 2. Washington, D.C., May 13, 1980.
  Part 3. Orlando, Fla., July 9, 1980.

How Old Is "Old"? The Effects of Aging on Learning and Working, Washington, D.C., April 30, 1980.*

Minority Elderly: Economics and Housing in the 80's, Philadelphia, Pa., May 7, 1980.*

Maine's Rural Elderly: Independence Without Isolation, Bangor, Maine, June 9, 1980.*

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  Part 1. Boston, Mass., October 24, 1980.
  Part 2. St. Petersburg, Fla., October 28, 1980.

Retirement Benefits: Are They Fair and Are They Enough?, Fort Leavenworth, Kans., November 8, 1980.*

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  Part 1. Washington, D.C., November 21, 1980.
  Part 2. Washington, D.C., December 2, 1980.

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Social Security—Continued
  Part 3. Washington, D.C., December 3, 1980.
  Part 4. Washington, D.C., December 4, 1980.
Home Health Care: Future Policy (joint hearing with Senate Committee on Labor and Human Resources), Princeton, N.J., November 23, 1980.*
Impact of Federal Estate Tax Policies on Rural Women, Washington, D.C., February 4, 1981.*
Impact of Federal Budget Proposals on Older Americans:*
  Part 1. Washington, D.C., March 20, 1981.
  Part 2. Washington, D.C., March 27, 1981.
  Part 3. Philadelphia, Pa., April 10, 1981.
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Social Security Reform: Effect on Work and Income After Age 65, Rogers, Ark., May 18, 1981.*
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  Part 1 (Short-Term Financing Issues). Washington, D.C., June 16, 1981.
  Part 2 (Early Retirement). Washington, D.C., June 18, 1981.
  Part 3 (Cost-of-Living Adjustments). Washington, D.C., June 24, 1981.
Medicare Reimbursement to Competitive Medical Plans, Washington, D.C., July 29, 1981.*
Rural Access to Elderly Programs, Sioux Falls, S. Dak., August 3, 1981.*
Frauds Against the Elderly, Harrisburg, Pa., August 4, 1981.*
The Social Security System: Averting the Crisis, Evanston, Ill., August 10, 1981.*
Social Security Reform and Retirement Income Policy, Washington, D.C., September 16, 1981.*
Older Americans Fighting the Fear of Crime, Washington, D.C., September 22, 1981.*
Employment: An Option for All Ages, Rock Island, Ill., and Davenport, Iowa, October 12, 1981.*
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Rural Health Care for the Elderly: New Paths for the Future, Grand Forks, N. Dak., November 14, 1981.*
Oversight of HHS Inspector General's Effort To Combat Fraud, Waste and Abuse (joint hearing with the Senate Finance Committee), Washington, D.C., December 9, 1981.*
Alternative Approaches To Housing Older Americans, Hartford, Conn., February 1, 1982.*
Energy and the Aged: The Widening Gap, Erie, Pa., February 19, 1982.*
Hunger, Nutrition, Older Americans: The Impact of the Fiscal Year 1983 Budget, Washington, D.C., February 25, 1982.*

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Problems Associated With the Medicare Reimbursement System for Hospitals, Washington, D.C., March 10, 1982.*

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The Impact of the Administration's Housing Proposals on Older Americans, Washington, D.C., April 23, 1982.*

Rural Older Americans: Unanswered Questions, Washington, D.C., May 19, 1982.*

The Hospice Alternative, Pittsburgh, Pa., May 24, 1982.*

Nursing Home Survey and Certification: Assuring Quality Care, Washington, D.C., July 15, 1982.*

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Long-Term Health Care for the Elderly, Newark, N.J., July 26, 1982.*

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Social Security Disability: The Effects of the Accelerated Review (joint hearing with Subcommittee on Civil Service, Post Office, and General Services of the Senate Committee on Governmental Affairs), Fort Smith, Ark., November 19, 1982.*

Quality Assurance Under Prospective Reimbursement Programs, Washington, D.C., February 4, 1983.*

Combating Frauds Against the Elderly, Washington, D.C., March 1, 1983.*

Energy and the Aged: The Impact of Natural Gas Deregulation, Washington, D.C., March 17, 1983.*

Social Security Reviews of the Mentally Disabled, Washington, D.C., April 7, 8, 1983.*

The Future of Medicare, Washington, D.C., April 13, 1983.*

Life Care Communities: Promises and Problems, Washington, D.C., May 25, 1983, stock No. 052-070-05880-3, $4.50.*

Drug Use and Misuse: A Growing Concern for Older Americans (joint hearing with the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging), Washington, D.C., June 28, 1983.*

Community Alternatives to Institutional Care, Harrisburg, Pa., July 6, 1983.*

Crime Against the Elderly, Los Angeles, Calif., July 6, 1983.*

Home Fire Deaths: A Preventable Tragedy, Washington, D.C., July 28, 1983.*

The Role of Nursing Homes in Today's Society, Sioux Falls, S. Dak., August 29, 1983.*

Endless Night, Endless Mourning: Living With Alzheimer's, New York, N.Y., September 12, 1983.*

Controlling Health Care Costs: State, Local, and Private Sector Initiatives, Washington, D.C., October 26, 1983, stock No. 052-070-05899-4, $3.75.*

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Social Security: How Well Is It Serving the Public? Washington, D.C., November 29, 1983.
The Crisis in Medicare: Proposals for Reform, Sioux City, Iowa, December 13, 1983.*
Social Security Disability Reviews: The Human Costs:
  Part 1. Chicago, Ill., February 16, 1984.
  Part 2. Dallas, Tex., February 17, 1984.
  Part 3. Hot Springs, Ark., March 24, 1984.
Meeting the Present and Future Needs for Long-Term Care, Jersey City, N.J., February 27, 1984.
Energy and the Aged: Strategies for Improving the Federal Weatherization Program, Washington, D.C., March 2, 1984.
Medicare: Physician Payment Options, Washington, D.C., March 16, 1984.
Reauthorization of the Older Americans Act, 1984 (joint hearing with the Subcommittee on Aging of the Senate Committee on Labor and Human Resources), Washington, D.C., March 20, 1984.*
Long-Term Care: A Look at Home and Community-Based Services, Granite City, Ill., April 13, 1984.*
Medicare: Present Problems—Future Options, Wichita, Kans., April 20, 1984.
Sheltering America's Aged: Options for Housing and Services, Boston, Mass., April 23, 1984.*
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A 10th Anniversary Review of the SSI Program, Washington, D.C., May 17, 1984.
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Low-Cost Housing for the Elderly: Surplus Lands and Private-Sector Initiatives, Sacramento, Calif., August 13, 1984.*
The Crisis in Medicare: Exploring the Choices, Rock Island, Ill., August 20, 1984.*
The Cost of Caring for the Chronically Ill.: The Case for Insurance, Washington, D.C., September 21, 1984.
Discrimination Against the Poor and Disabled in Nursing Homes, Washington, D.C., October 1, 1984.*
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Healthy Elderly Americans: A Federal, State, and Personal Partnership, Albuquerque, N. Mex., October 12, 1984.
Living Between the Cracks: America's Chronic Homeless, Philadelphia, Pa., December 12, 1984.
Unnecessary Surgery: Double Jeopardy for Older Americans, Washington, DC, March 14, 1985, Serial No. 99-1.
Rural Health Care in Oklahoma, Oklahoma City, OK, April 9, 1985, Serial No. 99-2.
Prospects for Better Health for Older Women, Toledo, OH, April 15, 1985, Serial No. 99-3.*
Pacemakers Revisited: A Saga of Benign Neglect, Washington, DC, May 10, 1985, Serial No. 99-4, Stock No. 552-070-00035-6, $25.

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The Pension Gamble: Who Wins? Who Loses? Washington, DC, June 14, 1985, Serial No. 99-5.

Americans At Risk: The Case of the Medically Uninsured, Washington, DC, June 27, 1985, Serial No. 99-6.

The Graying of Nations II, New York, NY, July 12, 1985, Serial No. 99-7, stock No. 052-070-06113-8, $4.75.*

The Closing of Social Security Field Offices, Pittsburgh, PA, September 9, 1985, Serial No. 99-8.

Quality of Care Under Medicare's Prospective Payment System, Volume I, Serial Nos. 99-9, 10, 11, stock No. 552-070-00161-1, $11.

- Medicare DRG's: Challenges for Quality Care, Washington, DC, September 26, 1985.
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Gramm-Rudman-Hollings: The Impact on the Elderly, Washington, DC, February 21, 1986, Serial No. 99-15, stock No. 552-070-01479-9, $5.

Disposable Dialysis Devices: Is Reuse Abuse? Washington, DC, March 6, 1986, Serial No. 99-16, stock No. 552-070-00501-3, $19.*

Employment Opportunities for Women: Today and Tomorrow, Cleveland, OH, April 21, 1986, Serial No. 99-17, stock No. 552-070-00632-0, $3.*

The Erosion of the Medicare Home Health Care Benefit, Newark, NJ, April 21, 1986, Serial No. 99-18, stock No. 552-070-00633-8, $2.50.*

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Medicare: Oversight on Payment Delays, Jacksonville, FL, May 23, 1986, Serial No. 99-20, stock No. 552-070-01372-5, $2.25.

Working Americans: Equality at Any Age, Washington, DC, June 19, 1986, Serial No. 99-21, stock No. 552-070-00818-7, $4.50.

The Older Americans Act and Its Application to Native Americans, Oklahoma City, OK, June 28, 1986, Serial No. 99-22, stock No. 552-070-00836-5, $6.

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Providing a Comprehensive and Compassionate Long-Term Health Care Program for America's Senior Citizens, New Haven, CT, July 7, 1986, Serial No. 99-23, stock No. 552-070-00849-7, $3.50.

The Crisis in Home Health Care: Greater Need, Less Care, Philadelphia, PA, July 28, 1986, Serial No. 99-24, stock No. 552-070-01503-5, $1.50.

Retiree Health Benefits: The Fair Weather Promise? Washington, DC, August 7, 1986, Serial No. 99-25.*

Health Care for Older Americans: Insuring Against Catastrophic Loss, Serial No. 99-26.*

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Part 2. Little Rock, AR, August 28, 1986.

Continuum of Health Care for Indian Elders, Santa Fe, NM, September 3, 1986, Serial No. 99-27.

Catastrophic Health Care Costs, Washington, DC, January 26, 1987, Serial No. 100-1.

Catastrophic Health Costs: Broad Problems Demanding Equally Broad Solutions (joint hearing with House Select Committee on Aging), Washington, DC, Serial No. 100-2.

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Outpatient Hospital Costs, St. Petersburg, FL, June 27, 1987, Serial No. 100-6.

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Reno, NV, August 17, 1987.
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Adverse Drug Reactions: Are Safeguards Adequate for the Elderly? Washington, DC, March 25, 1988, Serial No. 100-18.
Vanishing Nurses: Diminishing Care, Philadelphia, PA, April 6, 1988, Serial No. 100-19.
Adult Day Health Care: A Vital Component of Long-Term Care, Washington, DC, April 18, 1988, Serial No. 100-20.
Advances in Aging Research, Washington, DC, May 11, 1988, Serial No. 100-21.
Kickbacks in Cataract Surgery, Philadelphia, PA, May 23, 1988, Serial No. 100-22.
The Rural Health Care Challenge:
  Part 1—Rural Hospitals, Washington, DC, June 13, 1988.
  Part 2—Rural Health Care Personnel, Washington, DC, July 11, 1988, Serial No. 100-23.
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The Shadow Caregivers: American Families and Long-Term Care, November, 13, 1989, Philadelphia, PA, Serial No. 101-12.
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Skyrocketing Prescription Drug Prices: Turning a Bad Deal Into a Fair Deal, November 16, 1989, Washington, DC, Serial No. 101-14.
Medigap Insurance: Cost, Confusion, and Criminality, December 11, 1989, Madison, WI, Serial No. 101-15.
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